USING THE PSYCHOLOGICAL CONTRACT TO EXPLORE THE EXPERIENCES OF MIGRANT DOMICILIARY CARE WORKERS WITHIN LONDON

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ABSTRACT

This qualitative research makes use of the psychological contract construct and literature to explore the lived work perceptions and experiences of migrants undertaking domiciliary care work within London, in their multi- agency type of employment. The researcher examines these using the stories of forty four migrants employed in various types of contingent work arrangements. The participants are drawn from diverse employer types. Data interpretation and analysis was conducted using Interpretative Phenomenological Analysis and Hermeneutic Phenomenology. Initially, rich and thick descriptions are availed through an inductive analysis of the verbatim audio recorded interviews in presenting the migrant domiciliary carers' work experiences. In the next phase of analysis, the data is interrogated using the psychological contract thereby applying a more deductive approach.

This research sample is drawn from migrants of diverse ethnic and racial backgrounds, both male and female and uses the psychological contract to explore their work experiences, a novel approach from earlier research conducted on migrants performing domiciliary care work. The inveterate nature of idiosyncrasy, subjectivity, dynamism and the importance of the psychological contract in employment relations have been confirmed. Though migrant workers are usually seen as a homogeneous population, evidence from this research shows that these workers' are heterogeneous, each with a variety of views about their work experiences. Each of the participant interviewees held at least one type of psychological contract with the party or parties they deem to be in an employment relationship with and the experiences at work shape this contract.

DECLARATION

I declare that while registered as a research degree student at UEL, I have not been a registered or enrolled student for another award of this university or of any other academic or professional institution. I declare that no material contained in the thesis has been used in any other submission for an academic award.

ACKNOWLEDGEMENTS

DEDICATION

This work is dedicated to my mother Margaret for her nurturing presence and role in my life which has culminated in the fulfilment of my desire to pursue academic exploits.

TABLE OF CONTENTS

LIST OF TABLES

ORGANIZATION OF THE THESIS

In providing a lucid discussion, this thesis is structured as follows:

Chapter one introduces the research through providing an overview, the researcher's motivation in undertaking the research, the objectives and justification on why the research was deemed necessary. Further, eight arguments are adduced to point out the perceived gaps on existing knowledge that render the study feasible. The three terms that will constantly be used in this research; the psychological contract, migrant workers and domiciliary care work are introduced.

Chapter two presents extant literature reviewed on the psychological contract theory and construct. Literature is availed on the history and development of the psychological contract over the fifty years it has been in existence, as is a critical review of psychological contract definitions offered by various scholars. There are discussions on breach and violation and current research and discourse on the construct is also presented. There is also discussion of atypical employment forms and how this relates to the employee psychological contract. This is important given the large numbers of research participants who are engaged in non-traditional employment settings.

Chapter three offers a synopsis of social care, its definition and organization. The policy and law governing the sector is also highlighted. Domiciliary care which is the employment sector from which the research participants are drawn from is situated within the current Social Care Services and discussed in details for example; origin, important statistics, the personalization agenda and the variant forms. The salient features of domiciliary care are critically discussed as they form part of the migrant domiciliary care workers everyday work experiences. This chapter offers a distinction between domiciliary care and other divisions within the social care provision sector, paving way for an appreciation of the distinct lived work experiences storied by the research participants in subsequent chapters.

Chapter four discusses Migrant Labour, connecting the migrant worker to the domiciliary care they provide. A general overview on migration and its definition is provided along with examples of notable populations of migrant labourers that have been researched previously (including Eastern Europeans) and some underlying ramifications of migration and being a migrant are presented. Typologies ascribed to the migrants' behaviour patterns are also portrayed.

Chapter five acquaints the reader with the research methodology. The interview question and participants; story- telling are put forward. Variant forms of the phenomenological research approaches adopted in this study are explored, and a justification on why interpretative phenomenological analysis (IPA) and hermeneutic phenomenology (HP) were preferred. The Limitations of IPA are considered as well as an explanation of the research sample, justification for the large sample and comparative sample sizes in other IPA and qualitative research. There is a description of the coding process. The dilemmas associated with qualitative research methodology such as reliability, dependability, accuracy and generalizability are discussed. Ethical issues covering the research are also addressed.

Chapter six comprises the first of two chapters on the findings of the analysis of the data collected. It contains a presentation of the findings and discussions of the initial analysis of the narratives using an inductive approach. There is a recapitulation on the research objectives and the question asked to solicit information from the research participants. This chapter is further divided into two parts to ease comprehension. In part one, a story within the migrant domiciliary care workers is told. In the subsequent part two there is a presentation, interpretation and discussion of the five themes identified from the analysis of the narratives. Vignettes and extracts are interchangeably used to illustrate some of the verbatim accounts. This chapter sets in motion discussions on the findings of the perceived psychological contract in the next chapter.

Chapter Seven, is about the findings and discussions of the narratives in relation to the psychological contract. These are related to psychological contract typology literature and address the third research objective. Other broad spectrum findings that cut across themes that had been identified earlier are incorporated herein and discussed. Complementary and opposing findings are discussed and related to existing literature. This chapter importantly highlights the challenges of using a 'deductive' intervention in interrogating a research topic where the commitment in meeting the first two research objectives was inductive. It nevertheless describes the findings and discusses them using psychological contract literature drawing from the interpretation of the research participants' stories.

Chapter Eight, is the concluding chapter where there the key findings of the research are summarized and discussed in relation to the research objectives. There are statements about the contribution of this study, its limitations and opportunities for further research and recommendations. The epilogue provides a reflection about the research journey and lessons learnt.

CHAPTER ONE
INTRODUCTION

1.1 Research overview

This research covered three distinct but interrelated topics as the title **'using the psychological contract to explore the experiences of migrant domiciliary care workers within London'** suggests. Comprising this is the psychological contract, migrant labour and domiciliary care (a division within social care services). Most research conducted on psychological contracts has tended to be case studies of employees in specific organizations. This research used migrant employees working in various agencies within the domiciliary care division of the wider social care sector. Primary data was collected through a single interview question that encapsulated the objectives of the research. Narratives were used as they were deemed to offer the respondents the freedom to express themselves uninhibited. The prior permission and informed consent for audio recording of the narratives was sought from the research participants during their initial recruitment as participants for the interviews and further reaffirmed during the commencement and end of the interview recording. The choice of methods, that of a qualitative research, using Interpretative Phenomenological Analysis (IPA) and hermeneutic phenomenology (HP) for data analysis, provided for rich and thick descriptions of the phenomenon under study since generalization was not intended. After data collection a thematic analysis was undertaken. The themes most relevant to explicating the research objectives are presented in the findings and discussion chapters, as were selected verbatim vignettes of the research participants. Raw data and candid verbatim expressions were presented in the textual vignettes of selected research participants.

This research sought to understand the intangible aspects of the employment contract and the migrant care workers' perceptions of their day to day work experiences. Though it can be argued that a contract involves two parties, the research examined the psychological contract using interviews conducted with only one part of the employment relationship – migrant agency workers. In psychological contract research various scholars have investigated the construct from the employee view only. Examples of such studies include Jepsen and Rodwell (2012); Robinson and Morrison (2000); Rousseau (1989); Shore and Tetrick (1994); Taylor and Takleab

(2004). There have been contestations about the validity of using only one half of the parties to the employment relationship to study the psychological contract, bearing in mind that it is assumed that the contractual relationship involves more than one party and the matter is still the subject of fierce scholarly debate to date. Scholars for example (Conway and Briner, 2005; Guest and Conway, 2002; Guest, 1998) argue that the psychological contract is not really a contract if it is studied from the one side of the employment parties. However, even though the PC involves a relationship between two or more parties, it reasonable to look at this from the point of view of either party or both – but since this research is interested in the experience of the migrant workers it seemed fruitful to examine this from their point of view alone.

According to Dadi, (2012, p. 88) 'earlier researchers viewed the concept [psychological contract] as a perception resulting from an exchange agreement between two parties the employer and employee, but today the concept has grown globally to almost every interpersonal relationship such as between doctors and patients, the state and individuals, husbands and wives, teachers and students, football clubs and players, and lawyers and clients. Looking at the proposition by Dadi (2012) it can therefore be argued that even in a relationship where the domiciliary care worker engages in an exchange relationship with several parties, they may be construed to hold a psychological contract with the present party they are working for (including the sending employment entity and their client) as long as an exchange agreement is perceived to be existing. It is therefore also possible to study the psychological contract using the views of one part to the exchange relationship as this research does.

The decision to use a diverse group of migrant domiciliary care workers drawn from different organizations was also made as the focus was on the migrant worker's experience rather than the organization and recruiting from just one organization might be unnecasserily restrictive and pose difficulties in obtaining access. It is also important to note that the work experiences in the clients' homes are enacted away from the employer (using standard assumptions of one known organizational employer, which may not be the case for this group.) The data obtained was analysed in two stages - the first an inductive phase in drawing out key themes from the narratives, the second a more deductive phase, relating their accounts to the Psychological Contract literature. These experiences were encountered as they performed the multi-agency type

of employment; recruited by the agency and sent to work in the client's home and may even have to relate with members of the Client's family while attending to the Client. The research participants shared a common characteristic, that all of them were born outside the United Kingdom and could not trace their ancestry to a territory that would be considered part of the United Kingdom. This research tells the stories of migrant domiciliary care workers in their voice, a voice obtained through audio recorded interviews conducted during the research field work encounters. The lived work experiences of forty four migrants, 30 women and 14 men were investigated, recruited through snowball sampling. The participants gave their region of birth as being from Africa (Western; Eastern, Southern and North); Europe (Northern, Central/Eastern, Southern); from South Asia; Asia Pacific; the Caribbean's and Central America. Country specific place of birth for this group is availed in chapter 5 where the research sample is discussed. All were working in London.

Drawing on the psychological contract literature to be discussed in chapter 2 of this thesis, the data suggest that every migrant domiciliary care worker has at least one psychological contract, the psychological contract is dynamic, is informed and shaped by the experiences of one's life and in the work context by organizational (employment) experiences. A psychological contract is seen to be individually held. It is deemed to be present when one party assumes that a promise has been made. A psychological contract is not enforceable legally but its repercussions when violated can be far reaching.

According to Weiss and Rupp (2011) researchers often conceptualize constructs one way but employees experience it differently, hence the importance of studying the work experiences of migrant domiciliary care workers in relation to the psychological contract. Seeck and Parzefall (2008) assert that very little is known about employees' role in influencing the psychological contract and its content during every day work life and about their perceptions of their psychological contract obligation, and data was collected shedding light on this. Several researchers have postulated that many employees experience a power imbalance that hinders them from enjoying a mutually beneficial relationship with their employer (Conway and Briner, 2009; Dundon and Cullinane, 2006; Nadin and Cassel, 2007). Based on the findings of this research, both care workers (as a marginalized group) and their clients (resultant from the

conditions that necessitate their requiring the services of a carer) can be considered as a vulnerable population with the relations between the two perhaps being affected by the power imbalance shifting to the advantage of either as the situation may demand. The stories of the domiciliary care workers interviewed in this research parallel the aforenamed scholars' assertions.

1.1.1 Motivation for this research

The motivation for this research was threefold, first, out of a desire to examine the work experiences of migrant care workers working within London, second, to give this group an opportunity to have their voice heard and thirdly to blend the researcher's past experiences both as domiciliary care worker employed by an employment agency and that obtained as a human resources practitioner. The researcher has had close family members who have been resident in the United Kingdom for generations, the younger ones having been born here and therefore citizens by birth. Over the years, the researcher had been visiting the extended family members and then returning to their home country. However, the period 2007 to 2009 marked a different experience in their life while in London. This time, it was not to visit, but to undertake post graduate studies. Unlike in earlier times when the stay was short and mainly social, this time, the stay was for a longer period. Living with these family members was not viable given the location of the institution of learning. It required looking for and renting out suitable accommodation while attending university as an international assessed fee paying student.

Having had a successful career in human resources management at senior levels internationally, the researcher looked forward to working part time while undertaking further studies. This would also supplement their income and at least offset the high London living expenses. So, after settling into the new 'home' the researcher engaged prior human resource management skills and experiences to job hunt. It began by applying for jobs thought to be commensurate with their experience but part time since there was a clause on their student visa stating that only twenty hours a week during term time were allowed for work and that there was no recourse to use of public funds.

What began as an innocent job search soon turned into a nightmare. Most times, after applying for jobs the researcher was called for and attended numerous interviews; but unfortunately, it turned out to be one disappointment after another as no job was forth coming. Some of the feedback received from the prospective employers that the researcher assessed as over-qualified for the job they had applied for and had actually been shortlisted and interviewed for, other times it was opined that despite matching the advertised the job requirements, the position was better suited for a candidate with United Kingdom or European Union specific work experience. The researcher eventually realized and accepted that their attempts to get a job based on their past experiences gained through working in similar designations abroad had hit a brick wall. But there was a need to get some job, any job that would generate some income and also offers a chance to integrate socially during the student sojourn. It was during this period that the researcher was introduced to care work by a fellow male student who was working as a domiciliary care worker.

The first impressions about the job can be described as disturbing. Not only had the researcher never done care work for the elderly, but working in people's homes was different. There was a feeling of being a powerless intruder into the elder person's private home, yet at the same time there was an acknowledgment of the interdependent relations that grew between the researcher and the care service recipients. The researcher worked in domiciliary care services until the time of completion of studies after which the researcher returned to work in a senior level Human Resources Management in South East Asia following a successful recruitment process while still based in the United Kingdom.

Despite having good success career-wise, the memories of the stint in domiciliary care were alive in the researcher's mind. It is due to this that when a decision was made to embark on a PhD research programme, a topic about domiciliary care and the migrant workers doing it was an obvious choice. Through eliminating possible research topics, and given the interest in the lived work experiences of migrants, a study on domiciliary care workers was very appealing. From a background in human resources the researcher was familiar with the concept of the psychological contract and its use within human resource practice. Before writing my PhD research proposal, a literature review on the psychological contract was undertaken. Premised on

what was reviewed, a decision was taken to use the psychological contract construct and literature as the lens through which the experiences would be explored hence this thesis.

1.2 The Research Objectives

This research had three objectives namely:

1) To investigate the lived working experiences of migrant domiciliary care workers in their multi foci employment.
2) To examine the tensions within domiciliary care work.
3) To use the work experiences of migrant domiciliary care workers to scrutinize their psychological contract.

1.3 Justification for the research

Firstly, the notable presence of and the reliance on migrant workers in the UK care sector is a relatively new occurrence and there has been relatively little research on the phenomenon to date, as the later literature review in chapter 2, 3 and 4 will demonstrate. Though the social care sector employs many migrant workers to provide the necessary adult care services, the role and jobs of this substantial silent population is little understood. The research objectives provided data that will make a contribution to the existing knowledge and hopefully expound on Timonen and Doyle (2010) who argued that understanding migrant care workforce and the affective nature of formal care and relationships within the workforce is essential to ensure the well- being of both the carer and the care recipient.

Secondly, the UK has a growing number of aged people and with age there is an expectation that there will be deterioration of health and body agility, some of this may not necessarily require nursing in a residential setting but can be managed from a domiciliary setting (refer to chapter 3). There have been deliberate efforts to decongest hospitals and to also provide for personalized services where those eligible for state funded care can be catered for in the comfort of their homes. The entry of more women into the labour market has left a gap in the traditional setup where women were expected to take care of the infirm and elderly as part of their nurturing and household role. Research to be discussed in chapter 3 has shown that the rates and odd hours are not attractive for indigenous workers although there has been a slight increase in the numbers

taking on care provision related roles. However, this is mainly in senior roles. The geographical mobility and dispersion into different regions has led to an increase in the formal employment of non-kin care workers across the care provision sector (Badkar, 2009; Barret et al, 2006). Migrant care workers both male and female have to some notable extent filled this vacuum.

Thirdly, most of the research on migrant care workers has been on single ethnic groups (nationalities) for example on Zimbabweans (McGregor, 2007), on Filipinos in Italy and USA (Parrenas, 2000), on Filipinos in Singapore (Yeoh and Huang, 2000) and recently one on Indians (Ow Yong and Manthorpe, 2016). There is also a study by Lovelock and Greg (2015) which participants were Filipina women working in eldercare in New Zealand. There are relatively few studies conducted with migrants from diverse ethnic groups since a study by Timonen and Doyle (2010) whose research in Ireland involved South Asians, Africans and European care workers. This research seeks to fill the gap in knowledge on culturally diverse domiciliary migrant care workers by providing current information.

Fourthly, there has been an interest in the psychological contract, perhaps as a result of the breakdown in the traditional employment patterns where negotiations about employment were done in a tripartite setting (Guest, 2001; Coyle-Shapiro, Taylor and Tetrick, 2004). The increasingly idiosyncratic and varied nature of employment demands the application of a tool or framework through which the implicit and unvoiced expectations concerning employment issues can be investigated (Cullinane and Dundon, 2006). There is therefore need to explore this within domiciliary care provision, a sector that has undergone significant changes in the last decade. The objectives of this research as stipulated above can provide useful contemporary data insight into how employees manage their employment relationships.

Fifthly, the psychological contract can be used as a channel to understand how micro and macro changes to the employment relationship affect employees' experience of work (Conway and Briner, 2009). It has also been used to explain organizational changes for example the effects of downsizing (Feldheim, 2007), outsourcing (Agefalk and Fitzgerald, 2004; Koh, Ang and Straub, 2008), the shift from collective to and individual employee representation to market economies (Calo, 2006), transitions (Kase and Zupen, 2002). All the listed examples encompass the

developments in the domiciliary care workers employment sector and can, through findings from this study, be either corroborated or contradicted in light of the recent and on-going changes in social care provision.

Sixthly, the psychological contract is a construct that is frequently used in the context of management when defining the relationship between workers and employers (Atkinson, 2007, 2006, Davila and Elvira, 2007, Deery, Walsh and Iverson, 2006, Granrose and Baccili, 2005, Maguire, 2002, O'Neill and Adya, 2007, Schalk and Van Dijk, 2005). It therefore is suitable in the context of this research where the work experiences of migrant domiciliary care workers will be studied.

Seventhly, the subject of this research, which is the lived work experiences, is drawn from the participants' individual beliefs and these may vary from one person to another. Given that the psychological contract has been described as being based on individual reasoning (Roehling, 1997) using psychological contract literature may offer an understanding of these workers experiences. Until now there have been debates about whom, or with whom people engaged in atypical forms of employment form a psychological contract with. Who are the other party in this relationship? Is it possible to hold and maintain several psychological contracts simultaneously? When does psychological contract formation begin? (refer to chapter 2 for further discussion on the itemized queries). The work experiences of the research participants may offer some indication about answers to these queries to enrich current knowledge (see chapter 6 and 7).

Lastly, although there are a number of studies that have been held on employees' psychological contract despite an extensive literature search none comes to the researcher's attention as having involved the work experiences of migrant domiciliary care workers as shown from the examples here below.

Corder and Ronnie (2018) interviewed 13 nurses and 5 managers working within the health care system in a private hospital in South Africa. Shaddie (2012) investigated the relationship between flexicurity and the psychological contract in the health care and financial services sector in Finland. In wales, Wainwright and Sambrook (2012) interviewed participants drawn from a Welsh Community Learning Disability Team that provided integrated services in the NHS.

Corcoran (2012) conducted a survey on a comparison of the psychological contract of professionally qualified employees in the voluntary and private sector in Ireland. Flood (2009) explored of the Psychological Contract in a contemporary multi-national organization in Ireland. Cross, Barry and Garavan (2008) used employee perspectives to study the psychological contract in call centres. Van de Ven (2012) studied the consequences of contrasting operationalization of the exchange relationship in psychological contract fulfillment, affective commitment and turnover. Adams et al (2014) examined the determinants of the psychological contract using 292 respondents from Tema in Ghana. The researcher concurs with Li and Dai (2015) that there are still gaps in psychological contract research which this research seeks to offer contemporary data on.

1.4 Summary

In this chapter, an overview of the research has been provided, introducing the subject matter (the experiences of domiciliary care workers in London) and the psychological contract literature as well as the motivation that led to the researcher undertaking the project. The research objectives have been stated and a justification for why the research was deemed useful. This chapter summarizes the contents of the thesis and paves the way for chapter two which will review and discuss the literature on the psychological contract.

CHAPTER TWO
THE PSYCHOLOGICAL CONTRACT

2.1 Introduction

Having briefly introduced the psychological contract construct in the introduction chapter, this segment will make use of psychological contract theory as well as available literature to discuss the construct. It is also the first of three chapters which effectively form the literature review section of this thesis. The history, development and possible typologies that the psychological contract can take will be presented. This is in an attempt to offer the reader a deeper understanding and appreciation of the psychological contract. The prospective psychological contract of migrant domiciliary care workers has not been studied previously, though studies have been conducted on their experiences, though this study does not purport to measure or provide an answer on the psychological contract of this group of workers, it nevertheless provides some meaningful insights that can be explored further (see chapter 5,6 and 7). There has been a renewed interest in the psychological contract from the 1980's to date by both academics and practitioners as they seek novel people management practices amidst economic reforms, global business competition and fluctuating labour markets (Cullinane and Dundon, 2006; Guest, 1998). However, in reflecting on this attentiveness, it is crucial to acknowledge the contextual factors towards cultivating the psychological contract literature, as much of it has underpinned subsequent research and analysis (Herriot, 1992). The psychological contract is not a term used in everyday language but, rather it is one constructed by researchers (Conway and Briner, 2005). How the psychological contract can be related to the participants' storied experiences will then be discussed in relevant chapters within this research.

'The relationship between employees and their employers has been conceptualized as involving a psychological contract which refers to a set of beliefs regarding what employees are to give and receive with respect to their employer' (Roehling, 1997, p. 204). It has been suggested that 'in any engagement between two individuals in which a transaction occurs, there is an exchange, a giving and a gain of something by both parties with a consequent meeting of the needs in a reciprocal, mutual way' (Menninger, 1958, p.21). Even in a transaction involving more than two people the principle is similar only that the obligation is spread wider as is the situation in the migrant domiciliary care workers' multi-focal employments.

The psychological contract is so important in employee relations and organizational studies that various scholars have attempted to define it. An operational definition of the psychological contract for purposes of this research is as follows:

> *The psychological contract is: 'an individual's belief in mutual obligations between that person and another party such as an employer (either firm or another person) a belief being predicated on the perception that a promise has been made (for example employment or career opportunities) and a consideration offered in exchange, binding the parties to some set of reciprocal obligations' (Rousseau and Tijoriwala, 1998, p.697; Jepson and Rodwell, 2012).*

For example, when a domiciliary care worker is called by the agency and assigned to go and provide care services to a client, though the carer is not in a direct contractual relationship with the client, the carer goes and performs the duties as per the care plan. They go there believing that there will be payment for services delivered; there may also be more shifts in the future and that an employment relationship exists no matter how short the duration. It is important to clarify that this belief by the carer is an expectation in psychological contract terms.

A promise can be defined as 'a commitment to, or an assurance for, some future course of action such as providing the promise recipient with some benefit' (Montes and Zweig, 2009, p.1244) and 'involves a broad array verbal and non- verbal expressions of future intent' (Rousseau, 2001, p. 526) as well as a commitment to do or not to do something (Roehling, 2008). Psychological contracts refer to beliefs people hold about promises others make to them and which they accept and rely on (Rousseau, 1995). The psychological contract is distinct from a legal contract as the latter 'only offers a limited and uncertain representation of the reality of the employment relationship' (Daniels, 2010, p.1). Though a formal employment contract creates both parties rights and obligations, it does not shed light on how the relationship is developed or how productivity will be maintained (Herriot and Pemberton, 1996). Cullinane and Dundon (2006, p. 144) maintain that 'Since its conception the construct has been utilized to look beyond the legal contract of employment that exclusively focuses on the formalized aspects of work, to explore the subjective and indeterminate aspects of employee relations'. Given the idiosyncratic and manifold nature of employment, the appeal of the framework emanates from its focus on the individual's point of view, including their implicit and unvoiced beliefs about employment (ibid, 2006).

2.2 Early beginnings of the psychological contract construct

The idea of the psychological contract goes back more than fifty years and so it is not a new concept but the exponential growth in publications after the article by Rousseau (1989) may make it seem relatively new. Two phases in its development can be seen; the first from 1958-1988, the other from 1989 to date (Coyle-Shapiro, 2008). Menninger (1958) was the first researcher to instigate the concept of the psychological contract. In his book, *The Theory of Psychoanalytic Technique,* attention was drawn to the variety of interpersonal exchanges that focus on an explicit and unspoken contract between a psychotherapist and his/her patient based on findings from his research. He however did not use the term psychological contract to describe his proposition. Argyris (1960) conducted an ethnographic study in a manufacturing environment where he observed the employees and their supervisor and did not interview the employees. Given that in this job productivity could be easily calculated, he concluded that expectations were collectively shared by the whole group. He thus coined the term 'psychological work contract' to describe the unspoken expectations which underpin the employment relationship. He attuned Barnard's (1938) theory of equilibrium and that by March (1958) in his arguments. Barnard opined that employees' continued participation depends upon sufficient rewards from the organization. Improving on this, March and Simon (1958) introduced the inducements-contributions models. Their finding was that a greater difference exists between the inducement offered by the organization and employee contributions. The organization expects employee contributions to be sufficient in order to generate inducements while the employees expect attractive inducements to elicit their contributions. This is an important finding as it touches on whether there is mutuality between employer and employee obligations. This led to Conway and Briner (2005) arguing that, though the contribution by March and Simon (1958) is rarely acknowledged in psychological contract literature, the reciprocal exchange they found bears a resemblance to a core tenet of the psychological contract - reciprocity. Research by Taylor and Tekleab (2004) corroborated this by finding that employees exchange higher productivity and lower grievances for acceptable wages and job security.

A study of 874 employees in a large public sector organization by Levinson et al (1962), that investigated how work experiences affect the employee's mental health found that the psychological contract is 'largely implicit and unspoken' (Levinson et al., 1962 p.21). Individual

employees were identified as being the holders of expectations differing from the arguments by Argyris (1960) who emphasized the group's view. Expectations expressed by these employees had obligatory requirements. Criticizing Levinson et al., (1962), Taylor and Tekleab (2004) argue that the two parties in the psychological contract are the individual employee and their designated manager with expectations being somehow unclear hence requiring the circumstantial renegotiation of the psychological contract whose views must be elicited in investigating any psychological contract in organizations.

Levinson et al., (1962, p.21) describe the psychological contract as a 'series of mutual expectations of which the parties to the relationship may not themselves be dimly aware but which nonetheless govern their employment relationship to each other' and though not written into any formal agreement…' yet, 'operate powerfully as determinants of behaviour' (Schein, 1965, p.11). The mutual expectations are largely implicit and unspoken and frequently antedate the relationship of the person and the company (Roehling, 1997). In the case of the care worker there may also be such expectations in the relationship between carer and clients (on both sides) and these may or may not be similar to those between the carer and their manager/employer. Illustrating this example, the domiciliary care worker goes to the client's house in the hope and confidence that they will be allowed in, that they will perform their duties in accordance with the care plan and that they will be paid for this service. On the other hand, the client is expecting that the carer who comes will be empathetic to their condition, will be trained and have the ability to offer the required care services. In both cases the obligations are reciprocal though these are held individually. From this example, it can be inferred that the psychological contract began when either was informed that the other was going to meet their need, whether in offering a service or in receiving the service.

Even though the psychological contract entails expectations, not all expectations are contractual; (Robinson and Rousseau, 1994; Rousseau and Tijoriwala, 1998) for example, based on earlier employment experiences workers may expect an annual pay rise or performance appraisal, yet this may be neither explicitly nor implicitly captured in their legal work contracts. It has been suggested that obligations do not have the same contractual obligations as promises (Roehling, 2008; Rousseau, 1989) but Cassar and Briner (2009) argue that while promises are viewed as a

binding connotation in North American cultures, they may convey less commitment orientation in other cultures.

Moreover, if there is more than one person perceived to be the other party to a psychological contract, contradictory messages may arise (Conway and Briner, 2009; Coyle-Shapiro and Shore, 2007; Dabos and Rousseau, 2004). Migrant domiciliary care workers by virtue of their employment type have obligations to more than one employment party. The assertions by Conway and Briner; Coyle-Shapiro and Shore; Dabos and Rousseau and the tensions emanating from the contradictory messages may be examined in this research.

According to Schein (1970) the obligations alluded to by Levinson et al., (1962) determine behaviour. Levinson et al., (1962) gave a clinical psychological perspective in their findings while Schein (1970) borrowed from the motivational drivers of humans to understand the normative basis of the expectations. A point of convergence between Schein and Levinson et al is that both suggest that individuals enter the organization with their expectations already formed (Levinson et al, 1962, Schein, 1980).

Arnold and Silver (2005) observed that after Rousseau (1989), a plethora of literature and studies on the psychological contract has been established in a short period of time. This may be attributed to the concept's efficacy in explicating behaviour at work (Conway and Coyle-Shapiro, 2011). It is this literature that will form the discussions hereafter. Having introduced the psychological contract origins, attention will now move to the period after 1989 and various interpretations will be availed. Some criticisms of Rousseau's reconceptualization of the psychological contract is that it is subjective; about the individual as opposed to shared beliefs between the employer and the employee and that it does not consider that an obligation of reciprocity may encounter constraints in its implementation, therefore leading to feelings of breach or violation (Krivokapic et al., 2009).

The group versus individual nature of the psychological contract is a tension that is present in the on-going research and discussion around the concept of the psychological contract. It is a tension that, if resolved, would provide a rationale for the validity of the concept in developing employee and group commitment in organizations. Since this research did not intend to be generalizable,

the employees' experiences were treated individually as they narrated them, bearing in mind also that this study was not on organizations as the participants were drawn from various employments offering domiciliary care. The nature of the participants' job leads to the client being 'an employer' and these workers' job commitment or lack of it is enacted in the homes of their clients with a few references to short transactional encounters with their employment organizations over administration related matters. There are varied views about exactly who can/should hold a psychological contract. Is it the individual employee; the organizational agent (manager/supervisor)? Herriot, Manning and Kidd (1997) argue that Kotter (1973) insisted that only individuals within organizations can hold perceptions of obligations, organizations cannot hold perceptions and should not be anthropomorphized. Later writers take up the issue of anthropomorphizing in the context of the psychological contract and organizational voice (Marchington and Wilkinson, 2002). Writings, particularly within the practitioner field, often refer to a psychological contract between individuals and the organization. It is presented as if the organization has a consistent voice and expectation. The suggestion by Kotter that only individuals can hold perceptions and expectations undermines the concept that organizations have one set of expectations. What is frustrating in the literature of the psychological contract is that the term 'organization' is constantly so loosely defined, necessitating that later writers have had to clarify its meaning. Rousseau (2003) critiques the work of Meckler, Drake and Levinson (2003) arguing that they see the psychological contract as an agreement between management and the worker. In contrast, Rousseau does not support the notion that the contract is agreed between management and worker.

The dynamism of the psychological contract is evident when a comparison is made between Rousseau (1989) where in her re-conceptualization she argued that the psychological contract was in the mind of the employee only. Contributing to the discourse, Rousseau (1996) stated that the exchange agreement is between an individual and the agents of the firm. The individual's line manager or the human resources manager has been suggested as the person who sends out messages about expectations and obligations and therefore is the agent of the organization in the psychological contract (Herriot, Manning and Kidd, 1997). The idea of the organization speaking with 'one voice' is questioned and it has been suggested that organizations now place a greater emphasis on local job-related communication rather than top down information dissemination (Marchington, Wilkinson, Ackers and Dundon (2001). Non-typical working patterns, such as

15

teleworking and outsourcing, also bring into question the existence of a single psychological contract between an individual and the organization (Marks 2001). This view is particularly significant for this research as the participants work in non-typical work patterns some employees may be unclear as to who their organizational agent is.

Guest and Conway (2002b, p.22) suggest that most researchers agree that the psychological contract is a two-way exchange of perceived promises and obligations, offering their own definition as 'the perceptions of both parties to the employment relationship – organizational and individual – of the reciprocal promises and obligations implied in the relationship'. However Herriot, Manning and Kidd (1997), while discussing and supporting the mutual obligations between employer and employee, state that Rousseau (1990) and Rousseau and Parks (1993) indicate that it is in the mind of the employee only. It is a two-way exchange only in the sense that one party believes that promises have been exchanged and obligations have been created. If Rousseau and Park's observation is accepted the employer may have no knowledge of their perceived obligations. Yet it is a concept which has high face-validity with both employers and employees (Pate, Martin and McGoldrick, 2003) suggesting it is valued by both parties. In 2003 Rousseau extended her scope and investigated shared understandings between the employee and their employer. Her research concentrates on relationships within a research centre, between research staff and the centre directors. Her conclusion is that the terms of the psychological contract that employees believe to be mutual are indeed often shared by the employer (whose designation may be supervisor, line manager, or human resource manager). In the case of migrant domiciliary care workers, the employer may be the placing agency, a specific manager, the client or in some cases the client's family. Though determination of the mutuality/lack of mutuality between these 'perceived employers' is beyond the scope of the current research, future research may offer insights on this.

Beardwell, Holden and Claydon (2004, p.520) assert that 'the psychological contract is an individual's beliefs, shaped by the organization, regarding the terms of an exchange relationship between the individual employee and the organization.' In this study the psychological contract is understood as the individual's beliefs shaped by organizational experience and not shaped by the organization. Guest and Conway (2002) state that the psychological contract is premised on

the reciprocity between the organization and their employees' concerning perceived obligations and expectations. Per chance if over time the reciprocal patterns of giving and receiving inducements develop, then trust, loyalty and mutual commitments characterize this social exchange connection (Cropanzano and Mitchell, 2005). The psychological contract constitutes one type of social exchange within the employment relationship and it is individual employees and the employer's perceived current and future reciprocal obligations within the employment exchange which forms the basis for the contract (Coyle-Shapiro and Kessler, 2002; Rousseau, 1995). Under this view the psychological contract constitutes an unwritten agreement between the organization and employees and is based on promises and obligations (CIPD, 2003; Sparrow and Marchington, 1998). 'In complex relations obligations often heavily binding ones arise simply out of day to day operations, habits and customs which occur with little thought about the obligations they entail, or about their possible consequences' (MacNeil, 1985, p, 503). Obligations can be created from certain social norms such as reciprocity to visible patterns of employee-employer exchanges in diverse circumstances.

The researcher does not see the organization as a single entity and can therefore not be seen to hold a psychological contract in the same way as would an individual employee because the psychological contract when defined as the individual's set of expectations. Yet, an individual manager/client might have their own psychological contract, but the focus of this research is on the migrant domiciliary carer. Sarantinos (2007) views the psychological contract as offering a more realistic viewpoint of employee relations based on the parties' perceptions and can therefore have a greater influence than would a formal contract of employment. The interaction between employment contracts and the psychological contract with regards to the legal terms and conditions does affect perceptions of obligation (Sparrow and Marchington, 1998). Sarantinos (2007) further opines that in terms of strict comparison, the Psychological Contract is an implicit reflection of the employment relationship resembling a legal contract only on a broader scale.

The psychological contract in its current form is useful as an analytical tool to describe the employment relationship, and as a theoretical platform to understand employee responses to work place changes. Findings from a study conducted among 1306 senior human resource practitioners suggest that the psychological contract was instrumental in their considerations about how to implement employee relations within their organizations. The language used in the

psychological contract renders it an appropriate framework for studying relations at work as it has some direct parallels with the employment contract; this is because to some extent, it captures the individualization of the employment relationship associated with the growth of contract flexibility (Guest, 2003). The Psychological contract is adaptive to various societal elements, and can be seen as dynamic and changeable (Rousseau and Schalk, 2000; Thomas, Av and Ravlin, 2003).

A formal contract cannot capture all the elements of employment relations therefore the psychological contract can minimize employee insecurities, acts as an influencer of behaviour and may offer employees a feeling that they are conversant with organizational matters (Mc Farlane, Shore and Tetrick, 1994). The breakdown in older forms of employment relationships that involved tripartite negotiations between the employer, trade unions and the employee has provoked an interest in the psychological contract as a possible way to understand current employee relations (Guest, 2001, Coyle-Shapiro et al, 2004). Burke (1998) proposes that a psychological contract means that employees commit themselves to display high work performance in organizations and organizations are to provide employees with opportunities of regular work, training and promotions. This definition may be apt for use with professional employees whose type of psychological contract would be balanced with both themselves and the employer (organization) working collaboratively to enhance organizational and employee development. It may be possible that there might be different (perhaps lower) expectations by both for example in a situation where the employer is unable to gurantee regular work, training and promotions or in the case where the employee does not display high work performance. In such circumstances, the employee will hold a transactional psychological contract based on the absence of the criteria suggested by Burke (1998), Therefore the absence of agreement on the obligations of either parties does not prevent the formation of an employee's psychological contract, but may influence the type. Under the old psychological contract, the employer was seen in a benign way and as a caretaker for the employee (Coska, 1995; Ehrlich, 1994). Long term employment was prevalent with balanced and relational contracts being common (Kissler, 1994; Robinson and Rousseau, 1994). It has been suggested that the new psychological contract depicts a scenario where both employer and employee have lower expectations for long-term employment, and employees are responsible for their own career development; with commitment to the work performed, replacing commitment to the organization (Stroh, Brett and O'Reilly,

1994; Kissler, 1994; Parks and Kidder, 1990). To what extent the interviewees in this research hold something like this 'new' psychological contract is something to be examined.

Psychological contracting requires as a minimum a degree of personal freedom (Rousseau, 2000). 'The psychological contracts of workers and employers are shaped by societal factors such as freedom of contract, employment protection, the existence of a market economy, the relative power of the state and collective bargaining, though these do not necessarily have a direct effect on psychological contracts' (Rousseau, 2000, p.25). 'Social stability, to a minimum extent is a critical requirement for psychological contracting because before employment parties can create agreements regarding the future, both must have confidence in each other's intention and ability to keep commitments' (Rousseau, et al., 2000, p.5).

2.3 Psychological contracts prior to organizational entry and during employment

The point at which an employee forms their psychological contract and what influences this has been the subject of vigorous debate among psychological contract scholars. These are presented here. Irrespective of whether one defines the psychological contract from the promise or expectation divide they must ponder over when and how the employee psychological contract forms. People's life experiences have been found to have an influence on their expectations. The contract is not static; it changes over the course of employment (Arygris, 1960; Levinson et al., 1962) and this explains why at various times during the employment relationship, employees may experience feelings such as psychological contract fulfillment, breach or violation (Rousseau, 2000). Levinson et al., (1962) adjudge the psychological contract as being largely implicit with individuals forming and coming with expectations based on experiences external to the organization at entry into employment, whilst Rousseau (1990; 2001) highlights the antecedents of the psychological contract as being initiated by pre-employment experiences (for example, the job advert, information that they have been shortlisted, invitation to and attendance at the job interview, the job offer and through the early on the job socialization) in a specific and current job). By using examples of different occupational identities of academics originating from a business or medical background, Rousseau (2001) takes cognizance, though without expatiating, that previous occupational identity and interests may be influential to the formation of a psychological contract in new circumstances. This may be similar for the migrant

19

domiciliary carers who had other work profiles whether within or outside their current employments.

Thomas and Anderson (1998) have opined that new entrants into organizations have only rudimentary psychological contracts to which perceptions of obligations will be added during a period of socialization. On the part of the organization there is an expectation that a new employee will assent and abide by the organization's authority system as organizational roles are, 'a set of behavioural expectations, many of which are implicit and involve a person's sense of dignity and worth' (Schein, 1988, p.23). Schein (1965) identified three phases through which changes in an employee's psychological contract transition namely; at the commencement of their professional life, during professional development and the professional maturity of the employee. However, Rousseau (1989) and Mazur (2011) argue that it is the content of the psychological contract that changes and not the person who grows and matures, since the relation changes premised on the experience each of the employment partners have of each other. There are arguments that have been advanced implying that new migrants can take on any available jobs, but as they stay longer and become more knowledgeable about the job markets they move on into better jobs (Bauder, 2006; Datta et al., 2007; Parrado and Flippen, 2005). Findings from a longitudinal study by Devos, Buyens and Schalk (2003) showed new employees changing their perceptions from unilateral to reciprocal ones during the adaptation process. Takleab and Taylor (2003) noted that higher levels of socialization during the first three months reduced perceptions of employer obligations. This socialization may include a physical orientation within the organizational premises, health and safety (fire exits and assembly points), an induction period where the goal is to aid the new employee to attain an established worker's standard and organizational knowledge as quickly as possible, positive interaction with colleagues and their supervisor/manager, clear goal setting to enable performance appraisal during the probationary period and on-going feedback.

The researcher opines that if this is undertaken effectively, there is clarity on employer obligations and the employer may shape their psychological contract accordingly irrespective of 'off the job' employer obligations they may have held prior to their present employment. This may be ideal in formal work places with mature human resource management practices but may not be so in atypical employments types. In this study the experiences of the research

participations during their working life were explored. A study by Anderson (1998) on army recruits concluded that the recruits adjusted their psychological contracts over time due to acquisition of social knowledge making them almost similar to those of experienced soldiers.

Notwithstanding the influence of organizational strategies on the formation of the psychological contract, the exact constituencies of this contract vary depending on individual factors (De Cuyper et al., 2011). Such factors may be for example include the age of the employee (both for years of service and their biological age), ideologies and life experience; hence there is not a one size fits all in human resource practice attempts to guide employee psychological contracts. It has been established that co-workers are important at the point of a new employee's formation of the psychological contract as simultaneous self-management is coupled with management by colleagues and other members of the management team (Seek and Parzell, 2008 cited in De Cuyper et al., 2011). However, while not disputing the assertion by Seek and Parzell (2008) it is the researcher's view that the new employee cannot be assumed to be holding a psychological contract with the named organizational members based on the definition of a psychological contract by Rousseau and Tijoriwala, (1998, p.697) and Jepson and Rodwell (2012). What is happening can best be described as the formation of expectations and perhaps a feeling of being obligated to reciprocate depending on their experiences during their encounter with the colleagues. These interactions can either be good or bad and may leave an indelible impression on the new employee's future relationship with their colleagues. With regards to the organization an employee's organizational citizen behavior may be influenced by these initial contacts if they take the organizational agents as communicating the organization's policies.

There are a variety of factors that have been shown to influence the individual's psychological contracts including broad societal values and cultural norms (Sparrow and Cooper, 1998) as well as personality traits (DelCampo, 2007). According to Rousseau (2008) organizational information may also send cues to employees from which they construct their psychological contract content. Such information channels may be organizational (for example communications and human resource policies); dyadic (via manager-employee relationships quality; intra-individual {through dissimilar individual characteristics). However, the significance of these cues remains largely unidentified. Further research may be required in order

to ascertain Rousseau's claim perhaps through the use of an etic study. Five quantitative longitudinal studies were undertaken to assess changes in employees' psychological contracts at different times during their employment tenure. These include Anderson, 1998 (two waves); Robinson, Kraatz and Rousseau, 1994 (two waves); De Vos, Buyens and Schalk, 2003 (four waves) and De Vos, Buyens and Schalk, 2005 (two waves). However, even after such studies there is little understanding of the shape of individual contract trajectories on the content of supposed employer and employee obligations over time (De Vos et al., 2005). Interestingly, all the above studies applied linear contract change trajectories but it is reasonable to assume that curvilinear trajectories might be found. Research on breach and violation is conducted through distinct cross-sectional cause-effect methods but there is need to go beyond the collective employee reactions and focus on individual reaction. The domination of mono-methods may perhaps need to change to allow for studies in other settings. Available literature suggests that psychological contracts can change over time perhaps because of an employee's integration into the host country (MacKenzie and Forde, 2009) or due to their length of service in an organization (Piore, 1986) and that this is therefore an issue to be examined in this research.

2.4   Social Exchange Theory

At the onset, the psychological contract bore the semblance of an elaboration of the Social Exchange Theory initiated by Blau (1964); Homans (1958) and Gouldner (1960). Blau (1964, p.91) defined social exchange as the 'voluntary actions of individuals that are motivated by the returns they are expected to bring and typically do in fact bring from others.' Blau (1964, p. 93) argues that 'this type of exchange involves obligations which are not necessarily explicitly identified; for example, if one does a favour to another… while there is a general expectation of some future return, its exact nature is not definitely stipulated in advance.' The result is the creation of diffuse future obligations with either party expecting the other to reciprocate and honour their bit in the cause of the relationship (ibid. 1964). Recognized as one of the most influential model for understanding attitudes and behavior at the workplace it examines how social exchange relationships develop in engendering 'feelings of personal obligations, gratitude and trust' (Blau, 1964, p.94).

Coyle-Shapiro and Parzefall (2011) comment that the social exchange theory views the relationships between the employer and his employee as being motivated by economic and social needs which both parties have to collaboratively meet. Reciprocity - a term coined by Gouldner (1960) to describe the state where one responds to the actions of another based on how the first actor performed is now widely used in psychological contract discourse (Kiazad, 2010) and the subject of vibrant debate on whether it is one of the tenets that comprise a psychological contract. There is similarity between the social exchange theory and psychological contract theories in that both view exchange relationships as comprising tangible and intangible resources governed by the norm of reciprocity. Both theories also agree that each party brings to the relationship a set of expectations/obligations that they will provide in return for what they receive. The focus on obligations brings Rousseau's definition of the psychological contract very close to Blau's (1964) social exchange theory. However, although these researchers are conceptually close in capturing the nature of the exchange, they diverge in terms of its development.

For example, the other party to the exchange, the organization, has received more explicit consideration by psychological contract researchers; while the norm of reciprocity was more prominent and theoretically refined by social exchange theorists (Coyle-Shapiro and Parzell, 2011). Although the psychological contract shares some features with other employment and social exchange approaches for example equity and justice, organizational support and leader-member exchange, it also contributes uniquely to an understanding of breach (Conway and Briner, 2005) and this significantly distinguishes it from the social exchange theory. 'The Nature of the employment relationship has been an important but amorphous topic, probably since the very first time one individual struck a bargain with another, trading labour for otherwise inaccessible valued outcomes' (Coyle-Shapiro, Shore, Taylor and Tetrick, 2004, p. 1), hence the myriad approaches used in the understanding of this relationship. The robust theorization and research on the psychological contract has over time distinguished it and separated it from being seen as an addendum of the social exchange theory or any other theories that purport to address employment relationships.

2.5 An overview of Psychological Contract typologies

2.5.1 Introduction

Having established and demonstrated early in the discussion that a psychological contract does exist in any labour transaction where an exchange involves two or more parties; the next step is to show the variant types these can take. Notwithstanding the debate on this is on-going within psychological contract research circles. Psychological contracts can be as many as the people researching think they have identified. However, there are four types of psychological contracts that are widely accepted as being identifiable across most forms of exchange relationships. Employment relations are part of these exchanges. Where there is no actual measurement of the psychological contract as is the case in this research, the behaviour of people in organizational settings and their narrations of their work experiences can be used to aggregate the type of psychological contract they are likely to be holding. There is a consensus that the psychological contract is multi-dimensional (Freese and Schalk, 2008). Rousseau's relational-balanced-transactional-transitional typology has been adopted in this study as it is theoretically well established in psychological contract literature and also because they have been validated in studies (Ang and Goh, 1999; Ang, Kee and Ng's, 2000; Rousseau and Wade-Benzoni, 1994; Rousseau and Tijoriwala, 1998) and therefore allows for cross study comparisons.

However there can be an overlap and interplay between this typology. Expatiating this, Rousseau (1990) argues that transactional and relational psychological contracts represent anchors on a continuum and so the psychological contract can become more relational and less transactional and vice versa. Supporting Rousseau, Arnold, (1996) argues that training may be a transactional or relational item; that whilst in another study by Coyle-Shapiro and Kessler (2000) training emerges as an independent dimension. Whether these findings can be corroborated or negated was of interest in this research since it has already been established from the literature reviewed that the psychological contract is dynamic.

Transactional contracts

Transactional contracts assume an egoistic or instrumental model of human nature since employees are concerned about themselves as primary beneficiaries of the exchange (Rousseau and McLean Parks, 1993) with individuals holding this type of psychological contract exhibiting

low levels of affective commitment (Irving and Bobocel, 2002). Such contracts are positively related to careerism (Rousseau, 1990). They are exemplified by, 'a fair day's work for a fair day's wage' and focus on short-term and monetary exchanges; with the likelihood of a close-ended or specific time frame, a written role information where roles and duties are mainly static, the scope of influence narrow and the conditions are public and observable' (Rousseau, 1995, p.45). She further argues that 'there is little ambiguity, where routine tasks are performed and a proclivity for a high turnover rate as the terms make it easier to exit due to the substantial freedom to enter new contracts offered' (ibid, 1995).

Little learning takes place and when it does it is for job specific requirements with the tendency to make use of existing skills therefore not obligating an employer on employee development (Freese and Schalk, 2008). They imply a purely instrumental exchange relationship between employers and employees for services in exchange of compensation (Herriot and Pemberton, 1996) and serve employer short-term needs (Hallier and James, 1997). The commodification of care as well as the argument that domiciliary care is a labour process might promote the incubation of a transactional contract, providing the necessary ingredients for its germination. Such contracts are self-interested, based on reciprocity norms and carefully monitored by both parties and the exchange requires that the organization provide adequate compensation, a safe working environment in exchange for the employee's fulfillment of constricted, quantified role responsibilities (Thompson and Bunderson, 2003). Transactional contracting appears to replicate Kelman's (1958) concept where individual behaviour is predicted based on influencial attempts that involve the promise of reward and punishment. The rational choice theory would be applicable for explaining some of the motivations for holding a transactional psychological contract with Coyle-Shapiro and Neuman (2004) substantiating that exchange related dispositions influenced employee reciprocation.

The transactional orientation has been likened to continuance commitment based on the idea that both may bind an employee to the organization by instrumental interests (Milward and Hopkins, 1998). This type of contract may have a negative influence on the employment parties due to its calculative nature that offers little flexibility and discretion (Dabos and Rousseau, 2004; Chambel and Castanheira, 2006, 2007). Transactional contracts can be continued, renegotiated,

adjusted unilaterally or exited (Herriot and Pemberton, 1996). Transactional relationships have narrow scopes of agreement on work and have short limited work frames. Transactional relationships derive their legitimacy from legal-rational or pragmatic principles, outcome based and the calculative relationships are explicitly designed to provide tangible outcomes for both parties (Brown, 1997). The fixed short time-frame of the temporary worker may indicate that there was an expectation that the psychological contract formed during this period will be of the transactional type (De Cupyer and De Witte, 2006). Transactional contracts contain highly tangible exchanges that are economic in focus; the terms and conditions remain static over the finite period of the relationship and the scope of the contract is narrow (Coyle-Shapiro and Parzefall, 2008).

Relational Contracts

The relational contract is open-ended, with a weakly specified agreement that establishes and maintains a relationship based on emotional involvement and financial reward (Robinson and Rousseau, 1994) where the employer commits to stable wages and long-term employment, while the employee is obliged to support the organization and be loyal and committed to the organization's needs and interests (ibid, 1994). Relational contracts involve considerable investment by both parties to the employment contract and employees are also expected to invest in the acquisition of organization specific skills and long term career development whereas employers invest in extensive employee development (Rousseau, 2000). Relational contracts have both economic and emotional focus where the 'whole person' is included; are dynamic and the conditions are difficult for a third party to understand as their currency is socio-emotional (George, 2009).

In such contracts the parties pay attention to the fairness of the process rather than the fairness of the outcomes (Herriot and Pemberton, 1996). When a contract is perceived as relational, employees contribute their commitment and involvement to the organization mainly in the form of organizational citizenship behaviour (Robinson and Morrison, 1995), believing that the organization will provide loyalty; a sense of community and opportunities for professional growth (Thompson and Bunderson, 2003). Dishonoring this contract may provoke a re-negotiation of the contract in purely transactional terms (Organ, 1990) or in some cases exit and

the end of the relationship (George, 2009). Reward and recognition may be as important as they would be in a transactional contract (Irving and Bobocel, 2002).

Empirical studies (see Robinson and Morrison, 1995; Robinson and Rousseau, 1994; Thompson and Bunderson, 2003) have suggested that relational contracts have positive influencial outcomes for both employees and organizations, though this may seem so at a superficial level, the reality is that power is in favour of the employing entity (whether client or agency). Relational psychological contracts are negatively related to careerism and positively related to trust and acceptance of change (Rousseau and Tijoriwala, 1998).

The social normative relationships characteristic of relational contracts are based on moral legitimacy, implying a felt moral obligation to 'do the right thing' for relationship partners, regardless of the immediate personal outcomes, the moral responsibility being the underlying motive for meeting relationship obligations, as opposed to accountability for specific outcomes (Hofstede, 1980). According to Rousseau (1995) relational contracts require a high emotional involvement, imply growth and development on the job, there is also an expectation of job security, with dynamic work conditions and demanding a degree of socio-emotional trust. Hierarchical cultures are positively associated with transactional orientation and are negatively associated with relational orientation (Richard et al., 2009). However, some relational contracts when they experience or perceive breach metamorphose into transactional contracts in repraisal but the aggrieved employee does not quit the job (Rousseau, 2000).

Transitional contracts

These are cognitive states that reflect the consequences of organizational change and transitions that are at odds with an earlier employment contract (Rousseau, 1995, 2004). She further argues that it is a breakdown in contracts that bears the marks of few or no explicit performance demands or contingencies and can be seen in organizations that are closing down (ibid). An example of a time when employees may revert to this type of contract is during a merger or acquisition. In such situations there is mistrust, especially if the employer (old or in-coming) is inconsistent regarding their intentions toward the employee or if information is withheld and

there is uncertainty about obligations and an erosion of trust. Transitional relationships are characterized by mistrust and uncertainty (Rousseau, 2004; Jepson and Rodwell, 2012).

Balanced contracts

These are a type of psychological contract based on the economic success of organizations and the employee's opportunities to develop their careers (Rousseau and Wade-Benzoni, 1994). The contracts are specific and open-ended employment arrangements conditioned in terms of the economic success of organizations where both workers and the organization contribute to each other's learning and developmental needs (Wocke and Sutherland, 2008). Rewards to workers are based upon performance and contributions to firm's comparative advantages, particularly in face of changing demands due to market pressures (Rousseau, 2000).

The extensive use of short- term contracts and a perceived lack of commitment to and from the organization often results in a sense of short-termism and a constant concern for developing one's own career and curriculum vitae (Hardy, 1995; Reichers, 1985). The attributes of balanced psychological contract relationships are recognition of future internal and external employability and the changing nature of work (Fugate et al, 2004; Van Der Heije and Van Der Heijden, 2006). The contract is also referred to as 'team player' psychological contract. It has a high tangibility similar to the transactional one yet, also bearing a time frame akin to the relational one, there is high member commitment and on-going development with mutual support from the organization (Rousseau, 1995).This contract's distinctiveness corroborates the assertion by Rousseau (1990); Arnold (1996) and Coyle-Shapiro and Kessler (2000) on the psychological contracts being a continuum.

Psychological contract measurement

When dealing with the psychological contract measurement it is important to note that there are two perspectives that one can use; the etic and the emic. The first, the etic perspective, addresses the generalizable features using assessments that apply standardized scales to gauge the extent of transactional and relational arrangements in the employment relationship. A common framework is used across a multiplicity of situations (Morey and Luthans, 1984). The second, the emic, focuses on the local and idiosyncratic contents of the psychological contract. Ethnographic

interviews whose intention is to probe the subjective experiences of employees, with no prior framework to test, are an example of an emic perspective (ibid, 1984; Rousseau, 2000). The emic assessments avail qualitative descriptions of the idiosyncratic meanings given to employment (Arthur et al., 1999). This is the approach that this research has adopted which is similar to earlier seminal scholars such as Argyris (1962) and Levinson et al. (1962).

> *'The Psychological Contract Inventory (PCI) is designed to serve two basic purposes: 1) As a psychometrically sound tool for assessing the generalizable content of the psychological contract for use in organizational research, and 2) as a self-scoring assessment to support executive and professional education' (Rousseau, 2000, p. 2).*

Neither of the two purposes enumerated by Rousseau above was of interest to this research. Moreover, The PCI was designed to assess the characteristics of the employment relationships based on a conceptual framework grounded in organizational research (Rousseau and Wade-Benzoni, 1994; Rousseau, 1995; Rousseau, 2000). That the intention of this research was to provide a richer picture of the participants' work experiences and given the sample being drawn from different organizations, the researcher reasoned that the emic approach was more suitable for analyzing the storied work experiences which are presented in some selected vignettes and answering the first two research objectives.

One notable example of an emic study was that by Shore and Barksdale (1998) wherein the focus was shifted to content measurement as it was seen as situation bound and was generally more obligatory to both the employer and the employees under study. Their approach identified four types of psychological contracts namely:

❖ Mutual high obligations psychological contract
❖ This type is balanced and both the employer and employee having high obligations. It is positively related with affective involvement and high staff retention
❖ Mutual low obligations psychological contract.

This kind, though considered a balanced psychological contract has both parties having low obligations.

'The mutual obligations would result in stability, stable wages, trust and loyalty, while the mutual low obligations would b similar to a balanced psychological contract rested on economic success of the organization, external employability, internal advancement and continuous organizational and individual learning' (Shore and Barksdale, 1998, p. 10).

The other two as identified by Shore and Barksdale (1998) are perceived to be unbalanced, occurring less frequently and are temporal.

❖ Employer over-obligation.
❖ Employee under-obligation.

Where this is prevalent there are low levels of employee affectiveness, high intention to quit and a feeling of lack of organizational support. Similarly, where the employer is over-obligated it denotes bureaucratization, perhaps short term employment, and unambiguous role specifications. On the part of the employee this is a transitional psychological contract characteristic of organizations undergoing change, there is uncertainty and instability as employees will apply a wait and see attitude. The two approaches by Shore and Barksdale (1998) and Hiltrop (1995) rely on looking at both sides of the relationship (employer and employee) while this research is interested in looking at just one side. They offer an alternative to the approach taken by Rousseau which will be used to describe and define the psychological contract types that the participants may be holding as intimated from their storied work experiences. This research utilized the model proposed by Rousseau as it is the most widely used and other typologies do not represent an advance on it, only a different way of describing similar states of mind. Shore and Barksdale (1998) and Hiltrop (1995) were discussed here to demonstrate that other literature on measurement of the construct is available and was also reviewed.

2.6 Psychological Contract Breach and Violation

Under this section, psychological contract breach and violation are discussed. The two are not synonymous. A definition of the two terms by Suazo and Stone-Romero (2011) is that a breach is the perception by the employee that they have received less than what they were promised whereas violation is the depressing emotional state that follows a breach. Since the psychological contract is idiosyncratic and perceptual, what one employee perceives as breach may be violation

to another. Extant literature drawn from studies on the two will be conferred. To exemplify a case to demonstrate that breach may not necessarily lead to violation, the researcher provides the following example. In the case of an employee not getting an annual bonus as has been the norm at the end of the year in the previous years, they may realize and conclude that that is alright since it was an omission on their part not to equate the bonus payment being contingent on the organizational financial status especially since they have evidence that the organization was facing difficulties during this period. There is a breach but this does not evoke feelings of violation.

In illustrating a case of psychological contract violation, the researcher will borrow from some of the acts that can be considered to constitute gross misconduct on the part of the employee in mainstream employment circles [but in this case, reversed to misconduct by the employer, leading to a feeling of psychological contract violation unlike summary dismissal under the Employment Act]. It is worth mentioning that in the case of a domiciliary care worker, their employer may be the perpetrator of the psycholological contract violation; or that the very act leading to feelings of violation is committed within the client's physical premises. For example if a client is living with family members and the family member steals the carer's personal property (money or valuables from their purse or jacket) during the time when the carer is performing their care duties on the client. This is a really upsetting situation as it is the carer who will be expected to demonstrate that they actually came in with the possessions into the house, while the client may not want to believe that their loved one is capable of having stolen, yet the sending agency may tell the carer that it was their responsibility to ensure the safety of their personal property while at the client's house.

Acts of physical violence, sexual harassment, indecent exposure from a client who has mental capacity and does not require personal care against the carer evoke feelings of psychological contract violation. Though this research did not set out to investigate breach and violation, the experiences of the migrant domiciliary care workers interviewed can be understood better if the two counter-indications of the psychological contract are highlighted. A number of vignettes from the analysed data suggested that there are commissions on the employer part that the domiciliary carers could construe as bordering on either breach or violation. This will be discussed in chapters 6 and 7.

Psychological contract breach

A contract breach can be defined as the recognition by the employee that an employer has failed to fulfill one or more promises which the employee perceives to be obligatory (Coyle-Shapiro and Parzefall, 2011). Similarly, contract breach captures a cognitive awareness that some perceived obligation has not been fulfilled (Morrison and Robinson, 1997). In the performance of an exchange relationship, breach can be based on either genuine misunderstandings between contract parties which is termed incongruence or instances where a party deliberate reneges on

the deal (Conway and Briner, 2002). Research has indicated that broken promises have a greater effect on behavior and attitudes than unmet expectations (Zhao et al., 2007). There is contestation about the effects of breach on employee behaviours. Contemporary psychological contract theory postulates that the psychological contract is centered on promises and reciprocal obligations that develop in enduring relationships (McInnis, Meyer and Feldman, 2009). If this reciprocation is disrupted, it leads to a sense of a breach (Morrison and Robinson, 1997). There is acknowledgement that the process of reciprocity can arouse affective experiences such as affective commitment and job satisfaction (Tekleab and Chiaburu, 2011). Despite there being limited evidence on the relationship between union membership and the psychological contract, perceptions of contract breach relate positively to union commitment (Turnley, Bolino, Lester and Bloodgood, 2004). For example, an employee who feels that their employer is likely to commit a breach or that they are likely to suffer unfair treatment may join a union as a cautionary measure to ensure representation should the need arise.

Other scholars argue that breach can have a negative impact (Bordia, Restuborg and Tang, 2008; Jenson, Poland and Ryan, 2010). It is worth noting that low fulfillment is considered a form of response to breach of contract (Rigotti, 2009) but nevertheless not all employees quit their jobs following a feeling of breach (Zhao et al., 2007) and some choose not to withdraw their commitment (Ingram's, 2007; Kiazad et al, 2014). Before confirming that a commission or omission by the employer is a breach, it has been suggested that employees try to make sense of the incongruity (Morrison and Robinson, 1997). They may attribute this to a difference between employer and employee interpretations and beliefs about perceived obligations or alternatively a reneging where the organization agents are aware of the obligation but deliberately fail to fulfill it (Robinson and Morrison, 2000). Similarly Rousseau (1995) concurs and calls this evaluation process 'zones of acceptance' while Rigotti (2009) refers to them as 'thresholds'. He bases this on the findings of a segment regression analysis from his study on 643 employees in which all reactive outcomes by the employees, apart from that on organization commitment, occurred when the threshold level was exhausted.

Evidence from research shows that contract breach leads to reduced psychological wellbeing (Conway and Briner, 2002), increased intentions to quit (Tekleab and Taylor, 2003), reduced job satisfaction and also affects organization commitment (Coyle-Shapiro and Kessler, 2000). It reduces the trust that employees have in their organization (Robinson, 1996) and causes employees to have lower expectations on their obligations towards the organization (Lester et al., 2002). Conway and Briner (2002) also found that promises were deemed to be very important, similar to Kickul, Lester and Fink (2002) who saw procedural and interactive justice as moderating employee responses to breach. Intuitively, it can be suggested that in general breach leads to negative consequences but there may be some exceptions. Employees have also been seen to exhibit proactive and positive responses to breach (Pate, 2006; Parzefall and Coyle-Shapiro, 2011). Some research has suggested that contract breach was found to lead to employees decreasing their positive (Conway, Keifer, Hartley and Briner, 2014)   and increasing their negative (Bordia et al., 2008, Jenson et al., 2010).

Psychological contract violation

According to Rousseau (1989) violation is the affective state that may accompany breach of the psychological contract. Conversely, psychological contract fulfillment occurs when both parties find their obligations have been met (Conway and Briner, 2005). With regards to violation both the effects of a fulfilled and a breached contract must be examined (Cassar and Briner, 2011) for accurate interpretation. Borrowing from a form of the social exchange theory assumption, the psychological contract suggests that behavior operates on a tit-for-tat basis (Conway and Coyle-Shapiro, 2012). However, Kiazad et al., (2014) negated this when studying violation. Rayton and Yalabik (2014) argued that when individuals lose resources they may engage in extra efforts to reinstate their previous standing.

A study by Ducal, Coyle-Shapiro, Hinder and Wayne (2006) showed that violation mediated the effects of breach on employees' affective commitment and trust. Equity, sensitivity and external locus of control enhance the relationship between breach and violation (Raja et al., 2004). Contract violations encompass emotional distress, feelings of betrayal, anger and wrongful harm after an individual observes that the promises made by the other party have been broken. It is notable here that individual employees may have a sense of 'organization' as if it was something

like a person with obligations and promises even if the individual managers may or may not express views that coincide with this overall organizational view.

Existing psychological contract literature has been devoted to studying how fulfillment and breach affect the motivation to perform rather than the capacity to perform. The conservation of resources model argues that individuals are motivated to acquire resources and avoid losses through use of motivational measures rather than attentional measures which require cognitive functioning (Hobfoll, 2001; Rayton and Yalabik, 2014). Emotions can either enable or interrupt cognitive functioning (Forgas and George, 2001) and influence on-task attention and behaviour (Beal et al., 2005) given that psychological contracts attend to satisfying unconscious needs which if thwarted can trigger emotional reactions to enact coping mechanisms (Levinson et al., 1962). Resource based perspectives theorize that 'individuals endeavor to obtain, retain, protect and foster the things they value' (Hobfoll, 2001, p. 341).

2.7 Type of employment contract and the implications on the psychological Contract

Several studies have alluded to there being a relationship between the employment contract type and the employee's psychological contract. There are various types of contract under the present contingent working arrangements within the social care sector. Some of the benefits of fixed term and temporary contracts assist organizations in adjusting the workforce size, there is less investment in employee training and development and a reduction in indirect staff costs that such type of work arrangements avail (Van Hipple et al., 1997). Despite contingent workers being a source of knowledge creation within organizations, the fractured and fragmented manner in which domiciliary care is provided requires relatively low skills to undertake (Matusik and Hill, 1998). It has been shown that employees on non-standard employment contracts may have higher job insecurity, feel marginalized and perceive a loss of developmental opportunity in their career and organizational identification (Guest, 2003). There has also been growth in the number of employees who voluntarily choose to work under fixed and temporary contracts in line with their aspirations of engaging in a boundaryless career (Capelli, 1999; Arthur and Rousseau, 1995). According to McLean Parks, Kidder and Gallagher (1998), a better understanding of the differences in flexible employment contracts can be obtained through use of psychological contract dimensions such as stability, scope, tangibility, focus, time frame, particularism,

multiple agency and volition. Whilst this suggestion offers a framework for analysis, it may nevertheless present some formidable problems during its application as there is no one size fits all in organizational practice (there are multiple interpretations) and that the psychological contract is dynamic with the various holders having individual perceptions.

Several studies on the psychological contract have been conducted in the UK and overseas as discussed below.

A study by Millward and Hopkins (1998) found that temporary workers were more likely to perceive their contracts as more transactional than relational. Another study conducted using a large sample of local Government employees in the UK established that permanent employees reported statistically higher numbers of obligations and inducements, commitment and citizenship behaviour than did the temporary employees. However, the permanent employees also recorded significantly lower levels on their perceived organizational support (Coyle-Shapiro and Kessler, 2002). The findings from a series of random samples of workers in the UK comparing the psychological contract of workers on permanent, fixed term and temporary contracts concluded that workers on fixed term contracts reported a better state in their psychological contract (Guest and Conway, 1998). Further, a longitudinal study by Guest and Conway (2001) concluded that there were differences in the state of the temporary employees' psychological contract.

Guest, Mackenzie and Patch (2003) conducted a comparative study between contingent and permanent employees in the UK in which they classified contingent work contracts through fixed term and temporary agency types in their analysis. The findings suggested that workers on a fixed term contract and those on Agency contracts that were not temporary presented a better state of the psychological contract than the permanent workers (Guest et al., 2003). 'Objective job security refers to the probability that a worker will lose their job and have to change their employer. Subjective job security on the other hand is the perception that a job is more or less secure, whether or not there is objective evidence to support this' (Guest 2003, p. 15). Job insecurity is 'the perceived powerlessness to maintain the desired continuity in a threatened job situation' (Greenhalgh and Rosenblatt, 1984, p. 438). Kinnunen (2011) found that job insecurity may be more valued among involuntary temporary workers than perceived employability

although temporary workers compensate the loss of job security with higher perceived employability.

Research has been conducted in other parts of the world on the type of employment contract and how it mediates the employee's psychological contract. There are other studies whose focus was on the relationship between the employment type and job security, the findings consistently being that workers on flexible contracts reported lower levels of job security (see Kaiser, 2002; Parker, Griffin, Sprigg and Wall, 2002).

The behaviour of workers on temporary contracts may show more sensitivity to variations in the content of the psychological contract. A study in Sweden by Sverke, Gallagher and Hellgren (2000) on hospital workers concluded that workers on flexible contracts have higher levels of job insecurity. Basing their arguments from analysis of a sample of 2000 workers largely drawn from the public sector, Guest and Conway (2002) portrayed a negative association between fixed and temporary contracts and perceived job security even when other background factors were controlled as had an earlier longitudinal analysis (Guest and Conway, 2001). Results from a 1997 survey involving a random sample of 1000 UK employees focusing on job security showed that levels of subjective job insecurity were low as 37% felt very insecure, 49% fairly secure and 24% reporting being either very or fairly worried about their job security (Guest and Conway, 1997). Though this data was cross sectional, in the regression analysis, the psychological contract was more likely to affect job security than the job insecurity affecting the psychological contract (Guest, 2003). The psychological contract may play a vital role in mediating the relationship between objective and subjective job security. A comparative study between contingent and permanent professional service employees in Singapore found that the contingent workers had a more limited psychological contract about the organization's obligations and that the employment contract type mitigated the strength of the relationships between the psychological contract and work outcomes (Van Dyne and Ang, 1998).

Studies on Organizational commitment

There have been a number of studies addressing employee organizational commitment. This section has been included herein because a large number of the participants in this research were

engaged in atypical employments, some were contingent workers, while others were employed directly by the client or the client's family. It was found necessary to include this segment as it gives the reader an overview of studies on organizational commitment and how the employment type impacts on this. It is important to note that the participants in this study were not drawn from a specific organization and that their work is conducted in domiciliary settings where the client may also be seen as an 'organization' or 'employer' and the carer may have to pledge diverse allegiance to the different employment entitities. With whom do they hold a psychological contract, if they are multiple psychological contracts are they simultaneously held and can this be conflicting? There have been a number of studies in the US where most of the workers on flexible contracts are employed by temporary agencies. Such include research on the dual commitment to both the company and the trade union (Angle and Perry, 1986; Conlon and Gallagher, 1987). An examination of commitment from the perspectives of both agency and assigned employer using a social exchange model found that were that were independent forms of commitment, though commitment to the client organization was higher than that to the agency (Barringer and Sturman, 1999). Despite 30% of the participants preferring temporary work, their choice led to significantly lower commitment to the client organization.

Research on temporary agency workers in Japan by Gallagher and Fatugami (1998) and another conducted in USA (Newton McClurg, 1996) concluded that commitment to the temporary agency is positively associated to the number of work assignments and the tenure at the agency. A study by Porter (1995) in the US identified no difference between permanent and temporary nursing staff on levels of commitment and self-reported amount of work, quality of communication and quality of care. Tansky, Gallagher and Wetzel (1995) reported finding no difference in affective commitment between the temporary and permanent nursing and hospital workers studied.

Research findings from a study in Singapore by Van Dyke and Ang (1998) and another based on local government employees in the UK by Coyle-Shapiro and Kessler (2000) concluded that temporary workers displayed lower levels of commitment to the organization. Supervisors interviewed in a study by Ang and Slaughter (2001) rated temporary workers performance lower than that of permanent staff. However, there was a high correlation between performance ratings

and measures of obedience and trustworthiness. A comparative study by Ellingson, Gruys and Sacket (1998) found no differences in the ratings in client organizations in the comparative study on staff engaged on temporary contracts either by choice or those doing so out of necessity or there being no alternatives. For both groups performance measures were similar. Guest (2003) advocates for going beyond the distinction between contingent and permanent workers when incorporating a measure of the psychological contract to fully explain the relationship between employment contracts and behaviour.

Van Dyne and Ang (1998) and Coyle-Shapiro and Kessler (2002) argue that temporary workers engage in fewer citizenship behaviours. They can however change their behaviour in reciprocation to higher organizational support and inducements. Kidder (1995) cited by Van Dyne and Ang (1998) found no difference in the self-reported extra-role behaviour of both the permanent and contingent nurses in their study.

Previous studies (McDonald and Makin, 2000; Chirumbolo, Hellgren, deWitte and Naswall, 2003) indicate that surveys on non-permanent employees did not report reduced organizational commitment or job satisfaction. There are a number of arguments put forward to explain this finding. Non-permanent employees may show greater commitment as they are trying to impress their manager in order to secure a permanent position. Alternatively, job insecurity is an integral part of temporary employment and consequently their work attitude is not unduly affected. For some employees temporary and fixed term work is a conscious choice.

Some research comparing satisfaction of temporary workers on the contract of choice and those engaged in this contract, as it is the only one on offer, concluded that people on the contract of their choice were more satisfied (Ellingson, Gruys and Turnley, 1995; Marler, Barrringer and Milkovich, 2002). Studies by Guest and Conway (2002) and Guest, Mackenzie, Davey and Patch (2003) found that fixed term contract holders were found to be more satisfied than permanent employees. The temporary and agency workers had a higher job satisfaction level than the permanent employees prior to the introduction of the psychological contract dimension into the study whereby satisfaction varied immensely.

A study in Israel comparing temporary and permanent female office workers found that those who were temporary by choice had more satisfaction than both the permanent workers and involuntary temporary workers. Permanent workers reported more extrinsic satisfaction. This may have been due to the perks that came with their employment on permanent contract terms. The research participants reported similar levels of involvement and with low stress levels (Krausz, Brandwein and Fox (1995).

A study by Aronsson and Corranson (1999) on health and wellbeing found that the type of contract in an occupation of choice was more important than the permanent-temporary dimension. Those who reported the highest levels of headache and fatigue and slight depression were in permanent employment in a field not of their choice where they expressed feeling 'locked in' and being 'trapped'. They also had the lowest levels of support and opportunity to learn new things or to develop at work (Aronsson and Corranson, 1999). Isaksson and Bellagh (2002) conducted research on the impact of choice on measures of distress symptoms and somatic complaints among female temporary workers in Sweden. They found that having a choice in the type of employment contract led to fewer symptoms and complaints. During the regression analysis when other variables were introduced work load became the most noteworthy factor associated with negative outcomes (Isaksson and Bellagh, 2002). Quinran, Mayhew and Bohle conducted a study in France in which they closely reviewed flexible employment contracts including sub-contracted and self-employed workers. The findings showed a link between temporary employment and accidents and poorer work-related health (Quinran et al., 2000). An explanation for this may be the lack of /or inadequate training and access to information and material in the course of their contract. The temporary workers were also less informed about health and safety and voice at work.

Differences in the nature and magnitude of emotional experiences affect peoples' work attitudes and behaviour (Brockner and Higgins, 2001, George and Brief, 1996). The degree of valence whether general or specific shapes the emotional responses (Watson, Clark and Tellegen, 1988) with employees being more satisfied when their emotional experience is positive (Weiss and Cropanzano, 1996). Despite previous theory and research focusing on the relationship between employees' emotional experiences and their behaviour and work attitudes, organizational scholars devote less attention to the psychological processes that affect the nature and magnitude

of peoples' emotional experiences (Brockner and Higgins, 2001). This research through using the stories of the migrant domiciliary care workers paid attention to their emotional experience as evidenced in selected vignettes. This can be seen as a modest contribution to the existing knowledge.

Though commitment can be observed from tangible outputs such as good quality service, the psychological contract of the employee may be seen as the inner drive that causes employee commitment or the lack of it. These studies in the UK and elsewhere point to the salience of the psychological contract in examining the employment experience and the strong relationship between the form of employee contract and the psychological contract for the individuals involved.

2.8 Recent psychological contract research

The importance of the psychological contract in understanding organizational issues is evident from the studies undertaken across many areas including; the role of individual differences in psychological contract processes (Bal and Kooj, 2011; Hess and Jepson, 2009; Lub, Bal, Bloome and Schalk, 2016), on several moderating and mediating factors of psychological contract breach effects (Griep, Vantiborg, Baillion and Pepermans, 2016; Montes and Irving, 2008). Research has also been conducted on psychological contracts across cultures (Krishan, 2011, Raeder, Knorr and Hub, 2012, and within the not for profit sector (McDermont, Heffernan and Beynon, 2013).

Recent research by Rousseau, Hansen and Tomprou (2016) has acknowledged and produced greater construct clarity which has led to the psychological contract now being seen as comprising of perceived obligations derived not just from organizational promises, but also from pre-existing expectations. These developments are refinements to (Rousseau, 1995) on the psychological contract, two new theoretical approaches have been proposed, one by Rousseau, Hansen and Tomprou (2016) and another by Tomprou, Rousseau and Hansen (2015). Rousseau and colleagues (2016) have put forward a comprehensive phase model of viewing the psychological contract process, currently code-named PCT 2.O which is the product of ongoing collaborative research (e.g. Hansen, Zweig and Grief, 2015; Montes, Rousseau and Tomprou, 2012).

This model seeks to shed clarity on the processes during the employment relationship tenure. It commences with the 'Creation' stage (in which the initial development of perceived obligation happens), the 'Maintenance' phase (upholding and safeguarding the relationship status quo), the 'Repair' phase (following a negative event that affects the relationship) and the 'Renegotiation' phase (following a positive event) after which the psychological contract reverts to 'Maintenance' (O'Donohue, Hutchings and Hansen, 2017, p. 5). This model acknowledges the dynamism of the psychological contract and further examines the velocity with which work place events unfold as well as changes in employee perceptions about their own and the employers' obligations over time (Ibid, 2017).

The other proposition is a post-violation model (PVM) by Tomprou, Rousseau and Hansen (2015) that interrogates the employer-employee relationship during the psychological contract repair phase. It argues that a return to the maintenance phase is contingent to the parties instigating and enacting restitution and remedial emotional measures for the violation (O'Donohue, Hutchings and Hansen, 2017). Once formed, psychological contracts are quite stable and resistant to change (Coyle-Shapiro and Kessler, 2000; Rousseau, 2001). Nevertheless, this model identifies that once an employee's psychological contract is re-activated; a new employment relationship is formed, thereby making a re-establishment of a functioning status quo unrealistic (O'Donohue, Hutchings and Hansen, 2017). In furtherance of this some scholars have conducted studies that explore post-breach relationship repair (see Bankins, 2015; Grief, Vantiborgh, Baillien and Peperman, 2016; Sollinger, Hofmans, and Jansen, 2016). These recent developments may be beyond the scope of what this research examined but nevertheless demonstrate the importance of the employee psychological contract in organizational studies. If for example single organization on domiciliary care workers research is undertasken in forthcoming research, a longitudinal study can contribute to knowledge on this group of employees.

2.9 Conclusion

In this chapter pertinent literature has been reviewed to discuss the psychological contract construct. While the researcher does not purport to have exhausted all available information on the psychological contract, ample ground has been covered to integrate the construct to the experiences of the migrant domiciliary workers interviewed. The construct is interpreted differently by the various scholars, but its value in exploring the subjective experience of work for employees is evident.

The psychological contract can be used to explore phenomenon outside the conventional organisational   setups to include atypical employment. It is possible to explore the psychological contract of workers from different organisations but within the same job sector as evidenced by the fact that the participants in this study are drawn from various employers but within domiciliary care provision. Psychological contracts are potentially dynamic, and can change over time. In relating the concept of the individual psychological contract to care workers, and attending to their sets of expectations and promises made in the employment relation it should, however, be borne in mind that this may not be as simple as describing a one-to-one relationship between the employee and the reified organization.

Rather the employee might simultaneously hold psychological contracts with different people in the employment relationship. In the case where a domiciliary carer is attending to different clients during their shift, the carer may be capable of holding individual psychological contracts with each client. This may also be true if the carer is employed in more than one agency as they can also hold different psychological contracts with regards to the different employing agents. In exploring such complexity and richness, an emic approach was thought to be valuable. As intimated earlier, the next, chapter three considers literature on the umbrella social care sector and with specific attention to domiciliary care provision.

CHAPTER THREE
SOCIAL AND DOMICILIARY CARE IN THE UNITED KINGDOM

3.1 Introduction

The second under the literature review sections of this thesis, this chapter presents the extant literature that was reviewed on the social care sector and most particularly on domiciliary care, a component of social care in which the participants in this research work. Other services that fall under social care include residential care, care in the community and day care. Personalisation is discussed in detail as it is has emerged as an important feature in social care in recent years. The economic and social policy background covering domiciliary care is offered to aid the reader to have a better understanding of the stories of the participants on their work experiences. The salient features of domiciliary care are also covered as literature this is useful while analysing the stories of the research participants.

3.2 A synopsis of social care in the United Kingdom

An operational definition of social care for purposes of this research is 'the provision of personal care, protection and other practical support for adults with learning, physical and mental illness and disabilities who have been assessed as in need or at risk' (National Health Service and Community Care Act 1990). A care worker is a person who is employed to support the independence of individuals in need of that support due to disability, illness or frailty (ibid, 1990). Care workers provide a range of services including practical assistance, personal care, and emotional support. They can provide these services in residential or nursing care settings, in the person's own home or in the community. Care workers can be employed directly by social services, by private and voluntary organizations or by individuals who receive a personal budget or fund their own care (referred to as self-funding). A number of different terms are used to describe this role including: care assistant, support worker, personal assistant and in the United States of America, care giver, nursing aide and paraprofessional (Social Care Institute of Excellence, 2013).

Social care is an expanding sector in terms of employment, employing about 1.5 million people in the UK in 2012, often in small to medium sized organizations (Wilson, 2012). The prevailing normative context of caring premised on the supposition that care is a private issue which should remain in the domain of the family has hampered theorization of the meaning and consequences of care, rendering theoretical underpinnings of formal care in social science literature limited (George, 1998). This has however slightly changed as there are now a number of studies that attempt to offer an understanding about social care using various approaches (see Apondi, 2015; Equality and Human Rights Commission, 2015; Moya and Kay, 2017; Bolton and Wibbereley 2013). Howbeit, there is still room for further research.

Most adult care jobs are in domiciliary care (42%); residential (40%); community care (14%) and day care (4%) (Skills for Care, 2013). It is estimated that there were 1.63 million jobs (ibid, 2013) as some people included herein have more than one job. In contrast to some sectors adult social care has expanded during the recession and it is projected to continue to grow (Skills for Care, 2013). Sector wide (all social care components) approximately 1 in 10 care workers are aged 60 or over, with a large portion who work in the sector having begun working therein later on in their work life. Indeed 1 in 4 of the UK born social care workforce and about 1 in 5 migrants having started aged 44 or over (Franklin and Brancati, 2015). About half of workers in the sector are full time compared to 70% in the general workforce and 85% are employed permanently; whereas, the general workforce has 93% permanents (ibid, 2015). The average pay for frontline care roles in 2013-2014 was about £7.20 per hour compared to a living wage of £7.45 per hour outside London and £ 8.55 in London (Cangiano, 2014, Gardiner and Hussein, 2015). 82% of those in the social care workforce are women across all care. In terms of seniority 79% of the managers and supervisors are women (Franklin, 2014).

> Franklin (2014, p. 10) asserted that '*ethnic diversity can be observed in the social care sector with Black and minority groups at 17% of the total workforce. There is a dependence on non-British workers (18.3%) but, 92.4% of managers are more likely to be British in comparison to professional care workers (64.5%) and direct care workers (80.6%). The large number of care professionals who are non-British may be indicative of a skill gap across British born workers.*'

3.2.1 Organization of social care provision

In England, local authorities are responsible for the organization of social care (Lana and Lewis 1998) though most services are outsourced to private non-profit and for-profit providers. Funding from local government is strongly means-tested taking into account both income and assets, and needs-tested- being available only for those with high needs (Baldock, 2003; Wanless, 2006). The Region Savings threshold for local authority funding for 2018/19 is £23,250 for those living in England and in Northern Ireland; £27,250 for people residing in Scotland and £24,000 applicable for those in Wales (The money Advice Service, 2018). Therefore although it is assumed that all English citizens have a right to receive care services organized by their local authorities, this is not practically so because social care eligibility is subject to a 'means test' where those with income or assets above this have to fund care themselves or do without or rely on informal mechanisms via spouses, family and friends or neighbours (Van Hooven, 2012). A significant proportion of funding for adult social care is paid for by local authorities, the categories include those who are fully funded, self-funders and part local authority funded care service users who receive their budgets from the central government (Laing Buisson, 2014). Though local authorities are the single largest buyer of social care, the care market has a large number of small providers. The ten largest providers account for fifteen to twenty per cent of the total market share (Rubery et al., 2015).

In April 2013, there were about 8,000 registered home care agencies varying by local authority from one per 3,700 people to one per 14,000 people (Association of Directors of Adult Social Services, Annual Budget Survey, 2013). Central government defines the third sector as comprising 'non-governmental organizations that are value driven and which principally invest their surpluses to further social, environmental and cultural objectives' (Cabinet Office, 2007, p. 5). The Government has indicated that the third sector should have a much greater role in the delivery of public services. The Cabinet Office (2006, p. 3) set out a commitment to, *'the principle that where services are commissioned and procured by government, there must be a level playing field for all providers, regardless of sector'*. This interest in the third sector and its role in the delivery of public services is part of a wider focus on the supply side of public services and the role of commissioners in shaping improvements.

The Care Bill as announced by the Department of Health in 2012 provided a build- up on the Department's 2010 policy objectives. It was designed to simplify obligations on local authorities. It was anticipated that from 2015-16 this Bill would alter how authorities assess and fund the needs of adults as well as placing a limit on people's contribution to meeting the costs of their assessed care needs (UK Homecare Association, 2012). Presently, Central government sets national policy, the local authorities statutory duties and their total central funding. Most of this funding is however not ring-fenced and can therefore be spent elsewhere in the case of an unexpected deficit (Comptroller and Auditor General Report, 2013). The Care Act 2014 that came into effect from 1st April 2015 provides the most significant reform of support and care in over 60 years and aims to put people and their carers' in control of their care and support (Social Care Institute for Excellence 2015). The Act is a combination of various pieces of previous legislation and demonstrates how social care ought to be arranged in Britain, which was previously not transparent.

3.2.2 Quality in social care services

The provision of care in a variety of spaces is the outcome of complex relationships and interactions between the household, the economy and the state (Datta et al., 2006) as evidenced by the restructuring of care provision mainly associated with welfare cuts. Social care service is an intangible product that cannot be physically touched, felt, viewed, counted, or measured like manufactured goods that are tangible and can be sampled and tested for quality throughout the production process and even in later use (McLaughlin and Kalunzy, 2006). Since care services are simultaneously produced and consumed and cannot be stored for later use, quality control is difficult as the customer cannot judge 'quality' prior to purchase and consumption, hence social care outcomes cannot be guaranteed (Mosadeghrad, 2014). It is therefore difficult to define quality due to its idiosyncratic nature and intangible characteristics. However, knowing how to communicate and respond appropriately is essential to the delivery of quality care (Alzheimer's Society, 2014). Be that as it may, despite care regulation being in existence in the UK for almost three decades, the recurring scandals within the social care provision sector suggest that the care quality offered is not uniformly high (Kingsmill, 2014; Flynn, 2015; Rubery et. al., 2015).

3.2.3 Situating Domiciliary Care within Social Care

Since the study is about the experiences of domiciliary care workers, it is necessary to situate domiciliary care within the larger social care sector. The background to and evolvement of domiciliary care is discussed as well as legislation and policies that were enacted to actualise the envisaged domiciliary care during its initial inception. Domiciliary care has some features by which it is managed and even where such may be in use in the larger social care sector, they are adapted to fit their use in the client's house from which the assessed care is provided. This will be better understood through the discussions in later chapters within the thesis. Care in the Community (Community Care/Domiciled Care) is the policy where physically and mentally challenged people are cared for in their homes. The care that is provided by domiciliary care workers is not basic as this would suggest that it is of low level, but, rather it is fundamental and essential to enable a person to live a more independent life and maintaining their dignity (Age Cymru, 2016). In 2015 there were 510,000 jobs in Care Quality Commission (CQC) regulated within the voluntary and independent sector, with 18,956 being employed in the statutory domiciliary sector (Skills for Care, 2016). State funding accounts for about 80% service volume of the entire UK homecare sector (Holmes, 2015).

3.2.4 Early developments and advances in Domiciliary care

Domiciliary care today can trace its origin from district nursing provision and home help services created from the work of charitable organizations in the nineteenth and twentieth century. The period 1750-1850 saw England make great strides towards industrialization. As a result of this, family and community ties were loosened and enormous strain placed on the poor relief system (Dexter and Harbet, 1983). By the 1850's nurturing care to the poor within their homes was mainly provided by charities. Around the same period, schools for nurses were set up and by 1905 about 500 branches of district nursing were in existence (ibid.). These district nurses performed domestic roles that later came to be considered as part of legitimate work within the current domiciliary care service. Leece (2003) opines that the national government focus was on maternity and midwifery to address the high neo-natal, infant mortality and general poor conditions of children. Local authorities were empowered to provide domestic help in the home for pregnant women in a bid to operationalize this agenda which was further entrenched by the

Health Act 1936. By 1936 about half of the local authorities provided a home help service for home confinements (Dexter and Harbet, 1983).

The Second World War brought a large number of women into employments outside their traditional domestic spaces and into working in the factories. Under the new powers granted by the Defence Regulations, other categories of needy persons, apart from pregnant and nursing mothers were to be offered home help. By 1945 about 65% of all local authorities had home help schemes running alongside the Women's Voluntary Service (Hunt, 1970). Concomitantly, the bulk of health, social care and welfare benefits were brought into central government control under the new welfare state. The National Health Service Act (1946) established a health service available to the whole community. This service provision developed around a model that traditionally stopped short of providing intimate care tasks and domestic help (Leece, 2003). Since the 1950's respective governments were attracted to policy of community care in theory. About the same time there was attention by the media highlighting decay in the then institutional care. During this time there was growth in long-stay residential care. Since this was both a political, social and economic matter it required concise policies to effectively appease all interested stakeholders.

Pursuant to this, it was suggested in the Guillebaud Committee Report, 1956, p.11 that:

> *'Policy should aim at making adequate provision wherever possible for the care and treatment of old people in their own homes. The development of domiciliary services will be a genuine economy measure and also a humanitarian measure enabling people to lead the life they much prefer'.*

The 1950's saw a shift from large institutional care (orphanages and hospitals) toward care in the community. By 1957 all local authorities were providing a home help scheme in some form (Dexter and Harbert, 1993). By 1960, 75% of the total number of people receiving care obtained it in their home (ibid.). The Health Services and Public Act 1968 made provision of home help services a mandatory responsibility of the local authorities. The Disabled Persons Act (1970) ratified this obligation. During the 1960's and 1970's there was a lot of criticism about the quality of care provided in institutionalized setting (Audit Commission for Local Authorities in England and Wales). A case worth mentioning is the report from the Committee of Inquiry into allegations of 111 treatments and other irregularities in Ely Hospital, Cardiff; conducted in 1969

and presented to Parliament by the then Secretary of State. Progress on the implementation of this report was rather slow and it was not until 1986 when the government adopted a new policy of care in response to the 'Making a Reality of Community Care Report' prepared by the Audit Commission. The report outlined the slow progress in resettling people discharged from long stay hospitals. Means and Smith (1998, p.9) summarize The Community Care Policy objectives as:

> *'to cap public expenditure on independent sector residential and nursing home care; develop a mixed economy of care with a variety of providers and to redefine the boundaries between health and social care. This resulted in much of the care for the elderly and disabled persons were to be provided by the NHS being redefined as social care and local authorities being responsible for it.'*

In the 1970's there was uncertainty about the sustainability of the welfare system in England. Under the 'New Right' approach, it was argued that it would be necessary to free market forces to allow them to operate without constraints. Doing this would encourage alternative sources of welfare thereby increasing efficiency and more customer choice. During the period under review, domiciliary care was principally a cleaning service for older people that was provided by local authority home care departments (Leece, 2003). Cochraine and Clarke (1993) opine that a mixed economy of care developed, in the form of a quasi-market comprising of the informal, private, public and voluntary sectors.

The Griffiths Report 1988 titled 'Community Care: Agenda for Action' contributed in a big way to the development of domiciliary care as provided today. It recommended six key actions as abridged below:

1) *That so important were the recommendations that it required the ministerial authority of the Minister of State to ensure the implementation.*
2) *That local authority should play a key role in community care (for example Social Work/Services departments) instead of this being undertaken by the department of health in long term and continuing care.*
3) *That a specific grant be availed from the central government to fund the development of community care.*
4) *There were specifications on what Social Service Departments should do namely: to assess care needs of locality; set up mechanisms to access care needs of individuals on basis of needs and to design flexible packages to meet these needs.*
5) *Social work departments were required to collaborate with, and promote maximum use of the independent sector (voluntary and private welfare providers) to ensure success of the proposals.*

6) *Social Services were to have the responsibility for registration and inspection of all residential homes irrespective of whether they were run by the local authority or private organizations.*

However the recommendations that nursing staff be placed under the control of the local authority rather than the Health Boards did not materialize.

A White Paper 'Caring for People: Community Care in the next Decade and Beyond' was published in 1989 by the government as a response to the Griffiths Report along with a 'Working for Patients' paper whose recommendations suggested that state provision was ineffective and inefficient; that the state be an enabler and not a care provider, that there be a separation of the purchaser and provider roles and the devolution of budgets and budgetary control (Leece, 2003). The 1989 White paper factored all but two of Griffiths Report recommendations, it neither specifically designated a Minister for Community Care nor did it adopt a different funding for social care as proposed by Griffiths. It included recommendations on the establishment of a new funding structure; promotion of the independent sector; clearly defined agency responsibilities; development of needs assessment and care management; the promotion of domiciliary, day and respite care and the development of practical support for carers.

These objectives required new legislation which was enacted in the National Health Service and Community Care Act 1990.The implementation of the National Health Service and Community Care Act (1990) demanded enormous changes in the social care market. In response to the new challenges, a radical domiciliary care service was required for the successful implementation of the reforms (Wistow and Hardy, 1999). Many funds were transferred from the department of social security to local authorities to address the earlier perceptions about favouring those in residential care services at the expense of others in other care settings (Leece, 2003). Local authorities in England were now required to spend 85% of the Special Transitional Grant for Community Care in the independent sector rather than on their own services as was formerly the case. This led to a drastic increase in the home care purchased from the independent sector from just 2% in 1992 to 56% in 2000 (Ford et al., 1998; Mickelborough, 2002). Service allocation also required changes. The new emphasis shifted to that of providing large packages of care for those

on high dependency from the prior provision, unlike previously where small amounts of homecare were given to a large number of people.

By 1992 the average care hours received per person was 3.2, while by 1996 it was 5.6 hours and over the same period the number of households served had fallen by 11% (Government Statistical Service, 1998). The move to large complex care packages for highly dependent people necessitated the domiciliary care workers to undertake different tasks from those classified under domestic such as house cleaning, laundry, shopping and cooking to now providing personal care [for example bathing the client, dressing and feeding them and incontinence management] (Leece, 2003). For example, in 2000, 65% of local authorities home care staff chiefly provided personal care against 16% during the past 5 years (Taylor, 2000). The new domiciliary care work became more clearly defined and task based to meet the broadened tasks. This can be considered the beginning of the care plan and other accompanying domiciliary care time management documents that are in operation today. The community care reforms outlined in the 1990 Act have been in operation since April 1993. They have been evaluated but no clear conclusions have been reached. Some authors have been highly critical of the reforms for example Hadley and Clough (1996) who claim that the reforms 'have created care in chaos' as do Means and Smith (1998, p.13) who argue that the reforms:

> *'introduced a system that is no better than the previous more bureaucratic systems of resource allocation were an excellent idea, but received little understanding or commitment from social services as the lead agency in community care. The enthusiasm of local authorities was undermined by vested professional interests, and the service legacy of the last forty years ... health services and social services workers have not worked well together and there have been few 'multidisciplinary' assessments carried out in reality little collaboration took place except at senior management level because the reforms have been undermined by chronic underfunding by central government'.*

Political changes in England saw the coming into power of the 'New Labour' Government (Third Way). Their approach considered the welfare state as based on rights, duties and responsibilities (Blair, 1998). The business oriented social care system initiated by the conservative government was re-embraced (Cutler and Waine, 2001) whilst focusing on accountability to encourage more responsiveness to service users and tax payers (Clarke et al., 2000). This approach has, in broad terms, remained in place during the period of coalition and conservative governments since 2010.

3.2.5 Important Legislation covering domiciliary care provision

Domiciliary care in the twenty first century has undergone significant transformation. There has been the development of a greater number of 'for profit' organizations (Mathew, 2000). Various legislations has been either enacted or introduced to provide guidance in the management and sustainability of this labour market. This section highlights some of the main ones, albeit briefly. Unlike in the past The Care Standards Act 2000 is operational in England and Wales the regulatory system for social and domiciliary care has been placed within this regulatory framework. The National Care Standards Commission was established by the Act to cover both Health and Social Care. Local authorities are now required to meet the same standards as independent providers, even if they are the commissioning agents.

The General Social Care Council was established to register social care workers and set standards in social care work and training. In February 2003 a new guideline to end the two tier labour market for home workers was designed (Department of Health, 2003). Under this guideline all workers transferred to care agencies under the Transfer of Undertakings Protection of Employment (TUPE) have their terms and conditions protected, and this can result in staff working for the same employer but under different pay and conditions of service (Leece, 2003).

The National Minimum Wage Regulations 1999 indirectly affected domiciliary care, even though most agencies were already paying at the minimum rate or above, however it did lead to pay increases for other poorly paid industries such as retail and catering (Laing and Buisson, 2002).

The European Working Time Directive which came into force in October 1998 covers the minimum periods of daily and week rest, annual leave, breaks and maximum weekly working time and The fair Access to Care Services (DOH, 2001) implemented in April 2003 which provides local authorities with a framework to create eligibility criteria for service users based on needs and risks to independence.

3.2.6 Current domiciliary care services in the UK

This section highlights some of the pertinent information that gives an overview about domiciliary care presently. The domiciliary care sector suffers from a lack of routine or consistent data collection in all four administrations (United Kingdom Homecare Association (UKHCA), 2016). Owing to the devolvement of social care responsibilities in each nation in the UK, statutory requirements and regulations vary between each administration. However, some UK wide issues faced by all Administrations include instability in the national market, ever-increasing operating costs for homecare delivery and challenges with staff recruitment and retention, a downward pressure on the price paid for commissioned hours by the state and an ageing population (O'Brien and Francis, 2010). Pursuant to a growing concern about on the stability of domiciliary care in the UK, UKHCA undertook a survey in 2015 to assess the situation. Participants were providers trading with local authorities in Great Britain or Health and Social Care Trusts (HSCTs) in Northern Ireland. This Providers' survey conducted in September 2015 reported that the UK faced a real-terms decrease in price paid for services during that year. 93% of the interviewed providers claimed to have faced a real-term decrease in the price paid for services during this year, 20% recorded a reduction in the fees paid (UKHCA Market Stability Survey, 2015). 50% stated that though they had knowledge of existing tender opportunities they had declined to bid for service provision due to the low prices offered by the local authorities. 11% of those interviewed felt that they would 'definitely' or 'probably ceased their trading operations within the next twelve months. 38% were confident that they would still be in business next year (ibid, 2016). Interestingly, 74% of those who responded to the survey indicated their decision to reduce the amount of publicly funded care, a decision which if carried out would affect an estimated 50% of their current domiciliary care clients.

According to UKHCA retrospective data on state expenditure on domiciliary care in the UK is unavailable as prior to 2015 the devolved administration did not provide detailed data on their expenditure. Of note also, is that the methodology to record this expenditure varies across the local authorities. UKHCA using results from their 2015 provider survey estimate that in the UK in 2014/15, £3.9 billion was spent by local authorities to provide domiciliary care (UKHCA, 2016). In Northern Ireland the term Health and Social Care Trusts (HSCTs) is used to refer to what is known as local authorities in England. Nationally, the hours of domiciliary care delivered

and funded by local authorities HSCTs, have decreased at a relatively slow pace. Between 2009 and 2015 the hours of domiciliary care delivered in a sample week decreased by 6.8% (UKHCA, 2016).

For example, in England the total hours of domiciliary care purchased by local authorities in a sample week were as enumerated below.

Table 1: Total number of domiciliary care workers purchased by local authorities

Year	Weekly hours of domiciliary care purchased
2009	3,835,876
2010	3,511,695
2011	3,837,819
2012	3,606,861
2013	3,592,240
2014	3,558,995
2015	3,379,860

Source: Adopted from **Table 2 Total hours of domiciliary care purchased by local authorities and HSCTs in a sample week, 2009 – 2015**

Although the focus of this thesis is London, a part of England, information from the other parts of the UK is important to avail the most recent statistics to show the size and importance of domiciliary care.

Below is a display of the number of weekly domiciliary care hours purchased by local authorities in Scotland and Wales and by HSCTs in Northern Ireland individually.

Table 2: Weekly domiciliary care hours purchased by local authorities in Scotland, Wales and Northern Ireland

Year	Scotland	Wales	Northern Ireland
2009	645,700	224,244	235,559
2010	666,400	218,475	233,273
2011	683,900	214,642	224,473
2012	712,900	228,057	250,512
2013	631,100	245,305	249,381
2014	678,900	251,054	250,798
2015	706,000	262,242	255,309

Source: Adopted from **Table 2 Total hours of domiciliary care purchased by local authorities and HSCTs in a sample week, 2009 – 2015**

Table 3: Total weekly domiciliary hours purchased nationwide

Year	Total hours purchased Nationwide
2009	4,941,359
2010	4,629,843
2011	4,960,834
2012	4,798,330
2013	4,718,206
2014	4,739,747
2015	4,603,311

Source:–UKHCA Ltd (2016, p13).

As none of the nations in the UK accurately record data on the number of people receiving domiciliary care over the course of the year, assumptions of previous returns on annual weekly data of was applied by UKHCA to estimate the 2014/15 figures.

Table 4: Total people receiving domiciliary care funded by a local authority or HSC   Trust across the UK in sample week 2009 – 2015

	England	Scotland	Wales	N. Ireland	Total
2009	357,545	68,579	25,685	23,377	475,186
2010	337,125	66,224	25,253	23,389	451,991
2011	322,660	63,460	24,638	23,522	434,280
2012	298,390	62,832	24,505	24,134	409,861
2013	281,550	60,950	25,205	25,330	393,035
2014	278,815	61,740	24,794	24,189	389,538
2015	273,124 *Estimate	61,500	23,744	23,260	381,628

Source:–UKHCA Ltd (2016, p13).

There was a 20% decrease in the number of people receiving domiciliary care funded by a local authority or HSCT in the period 2009-2015 in England and Northern Ireland. This can be attributed to several factors for example, the legislative changes in England and Wales which introduced national eligibility criteria, meaning that local authorities can no longer set eligibility thresholds and a diversified care market (UHCA, 2016).There has also been a departure from earlier domiciliary care purchase patterns where there was prevalent use of block contracts. In exercising their personalization preferences, service users are now micro-commissioning services direct payments, individual service funds, private insurance and from their personal resources (UKHCA, 2016, p. 14). Importantly, though the figures show a decline, this does not necessarily mean that the total amount of domiciliary care provided has decreased. These figures represent local authority funded care and the austerity measures the local authorities have undergone may be reflective of this. There may well be an increase in self-funded care by an ageing population that don't meet the eligibility criteria for LA funded care.

Despite there being a sizeable privately funded care market in the UK, data is not routinely collected. Data on self-funders is sparse but, applying data from the NHS England Commissioning Board Report 2014/15 UKHCA estimate that expenditure on domiciliary care by self-funders in 2014/15 was £713 million (UKHCA, 2016).

The economic statuses of inhabitants of a place may impact on the number of people receiving privately funded domiciliary care. The table below illustrates this.

Table 5: Economic statuses of persons receiving privately funded (self-funders) domiciliary care

Hours of Care Purchased (Annual)	Hours of Care Purchased (Annual)	Expenditure (£) (Annual)	People Using Services (Annual)
England	73,052,000	652,000,000	207,509
Scotland	2,788,618	63,652,174	9,311
Wales	2,227,598	15,435,895	7,731
N. Ireland	700,885	10,745,192	2,448
Total	78,769,096	741,833,261	226,999

Source: Adopted from Table 6: UKHCA Ltd (2016, p. 13).

3.2.7 Domiciliary care workers Nationality

According to The National Minimum Data Set – Social Care (NMDS – SC) figures on the nationality of domiciliary care workers in England 2016 are British - 65.4%; European Economic Area (Non British) - 4.6%; Non- European Economic Area – 7.0%; Unknown – 22.2% and non-British unspecified – 0.8% (Skills for Care, 2016). It is important to note that the category described as British denotes nationality and includes people who if not for the use of this term would probably fall into any of the other listed categories. Some may have other non-British ethnicities but have since acquired British citizenship therefore describing themselves as British.

3.2.8 Personalization

It would be inconceivable to discuss and understand domiciliary care without its accessory – personalization. Personalization as discussed in this section offers a deeper insight into how domiciliary care is offered as are definitions and forms as well as the background to the model. Personalization is vital especially for persons with physical and mental disabilities as well as those with mild to moderate care needs that none-the-less require assistance. The central government defines personalization as 'the way in which services are tailored to the needs and preferences of citizens where the overall vision is that the state should empower citizens to shape

their own lives and the services they receive' (HM Government Policy Review, 2007, p. 7). Leadbeater (2004, pp. 18-19) suggests that personalization is 'a new organizing logic for service provision…as influential as privatization was in the 1980s and 1990s in reshaping service provision'.

Personalization had become a central theme in the reform of social care under the New Labour government (Darzi, 2007; Darzi, 2008; Department of Health, 2009; Department of Health, 2007), but is by no means a new concept. Furthermore, as Pykett (2009, p. 393) notes, 'an interest in personalization is not confined to England but references to this are made by the other UK governments of Wales, Scotland and Northern Ireland, in addition to Canada, New Zealand, USA, Australia, France and South Africa'.

Personalization has also been identified as being 'a cornerstone of the modernization of public services' (Department of Health, 2008: p. 4). 'Personalization is about giving people much more choice and control over their lives and goes well beyond simply giving personal budgets to people eligible for council funding'(Social Care Institute for Excellence, 2009, p. 1). Harlock (2009, p. 8), states that 'personalization is still evolving in terms of policy, implementation and practice and how we can turn the rhetoric of personalization into an effective reality is as yet unclear'. As argued above, for a considerable period of time growing dissatisfaction has been expressed by disabled people about a lack of flexibility and the unreliability of welfare services. Traditional modes of social delivery have been seen as leading to the dependency of individuals, rather than promoting independence, thereby preventing disabled people from obtaining full citizenship rights (Morris, 2006). Boxall et al (2009, p. 504) argue that those promoting personalization often contrast the 'one-size-fits-all' approach of standard services with this more 'personalized' approach where services and supports are tailored and customized to match the needs and preferences of an individual, offering them 'choice and control'.

Personalization is therefore a broad outcome in the sense that it is ultimately about active citizens (as opposed to passive recipients), co-producing services which allows them to live life in a way in which they have determined. Lucas (2012) states that there appears to be consensus that social care should be delivered on personalized basis to meet the distinct client needs and to foster

independent living. However, personalization is not uncritically accepted as a positive development by all commentators. Ferguson (2007, p. 401) argues that,

'in its uncritical acceptance of the marketization of social work and social care; in its neglect of issues of poverty and inequality; in its flawed conception of the people who use social work services; in its potentially stigmatizing view of welfare dependence; and in its potential for promoting, rather than challenging, the de-professionalization of social work, the philosophy of personalization is not one that social workers should accept uncritically'.

David Miliband (then Minister of State) argued that a personalized approach reflects a 'model of service delivery that overcomes the limitations of both paternalism and consumerism' (Miliband, 2004, p. 11). What this kind of perspective suggests is that personalization is more than a set of specific policies, but is instead linked to the type of philosophy that underpins the design and delivery of welfare services. As Pykett (2009, p. 375) argues,

> *'What is at stake within debates on personalization is a question of the government's duty to ensure the welfare of its citizens. Personalization is not a mechanism for public service reform. Rather, personalized services that meet the needs of the individual service user are one of the key objectives of such reforms.'*

3.2.9 Forms of personalization

The shift from cramming people with health and social challenges that could be handled under domiciliary care into residential accommodation was a precursor to the personalization agenda. Implementation and operationalization of personalization was undertaken through various means as discussed below.

Direct payments

A direct payment is a financial transaction which a local authority makes to an adult who has met the eligibility threshold for them to use in meeting their assessed needs (UKHCA, 2016). Described as holding out *'the potential for the most fundamental reorganization of welfare for half a century'* (Oliver and Sapey, 1999, p. 175), the 1996 Community Care (Direct Payments) Act give people using social care services access to direct funds with which to design their own support. This Act overturned aspects of the National Assistance Act 1948 that prevented local authorities to provide cash payments to disabled people. Until this time the system of care that had been developed might be described as 'bureau-professional' (Clarke *et al.*, 1994) where

disabled people were assessed by professionals and then assigned to services on the basis of availability.

Since 1997, disabled people in the UK eligible for adult social care have been able to opt to receive 'direct payments.' Originally pioneered by disabled people in the US, this way of working was introduced to the UK in the 1980s by disabled people's organizations, promoted by disabled people during the early 1990s, and introduced only after sustained lobbying by disabled people (Glasby and Littlechild, 2009). Subsequently, it has been disabled people who have been most active in providing support to direct payment recipients and in campaigning for further extensions and greater take-up. Almost more than any other current policy, this is a concept developed, implemented and rolled out by disabled people themselves. From the beginning, the campaign for direct payments was seen as part of a broader struggle for greater choice, control and independent living, with disability re-defined as being the social, cultural and attitudinal barriers to disabled people participating as equal citizens, rather than in terms of individual impairment (Oliver, 1996).

Scourfield (2005) argues that this Community Care (Direct Payments) Act 1996 was symbolically important as it demonstrated that the government of the time was taking the voice of disabled people seriously. While direct payments can be used to purchase services from a voluntary or private sector agency, many people choose to use the money to employ their own personal assistants (PAs), essentially becoming their own care managers. Initially discretionary, direct payments were soon extended to other user groups (including older people, carers, younger disabled people and people with parental responsibility for a disabled child), became a key performance indicator and were made mandatory (for people who meet the criteria and want to receive a direct payment). Scourfield (2005) and others (Jack, 1995) have argued that changes such as the Direct Payments Act only represent a 'qualified form of empowerment' (p. 470) as they do not alter the basic needs-based and means-tested basis of the English welfare system. Therefore, a key limitation of direct payments is that they have often been bolted on to existing traditional systems, where it is argued that disproportionately onerous financial monitoring has on occasion, reduced the scope for innovation (Glasby and Littlechild, 2009).

Even though new ways of working inevitably incur a series of start-up and management costs, it seems as though direct payment recipients have more of a vested interest than the local authority in ensuring that each pound available is spent as effectively as possible and in designing support that enables them to have greater choice and control over their own lives. While take-up is inconsistent and low compared to the number of people who receive directly provided services, any remaining barriers seem to be the result of the way in which direct payments have been operationalized rather than of the concept itself. Where direct payments have been taken up enthusiastically, the biggest successes have often come where there is a user-led Centre for Independent Living providing advice and peer support. However, as Kirshenbaum (1999) warned the English social service departments have limited budgets, mechanisms like direct payments might result in an upper limit being imposed on individual care packages. Moreover, in concentrating on individual service provision, there is a danger that collective service provision might be undermined. In the longer term, research into these issues will be needed in order to fully assess the impact of these changes.

Personal budgets

Having had experience of Direct Payments, the Government pledged to implement personal budgets across the whole of adult social care (Department of Health, 2008). This saw the emergence of Individual/personal budget. It involves being clear with the person from the outset how much money is available to meet their needs, then allowing them maximum choice over how the money is spent/how much control they want over the money (Ferguson, 2007).

In Control is a national social enterprise, independent from government, which developed the concept of personal budgets and is supporting local authority members to implement this way of working (Hatton, 2008). People new to direct payments can benefit from the consultancy and advisory services offered by In Control. Initially, the individual budgets developed by In Control were for social care funds only. Subsequently, Department of Health pilots began to explore scope for integrating a series of additional funding sources. 'Individual budget' refers to a single pot with the potential to bring together all the various funding available to the individual (ibid, 2007). Some individuals may be in receipt of an assortment of benefits from various entitlements that they qualify for (for example additional funding streams, including various social security,

housing and employment support funds etc.). Pooling all these into one account may reduce the administrative costs accruing from multiple transactions and the time spent by the disabled person as they follow up these benefits.

Since 2003, personal budgets have been implemented with around 12,000 people. The evidence suggests that not only do personal budgets seem to be delivering their primary purpose of giving people more control over their own support; they also seem to lead to overall improvements in well-being and to greater efficiency (Poll et al 2006; Hatton et al., 2008). Early pilot work with 60 people in six local authorities demonstrated improved satisfaction, improved efficiency, increased use of community and personalized support, and an improved ability for individuals to make desired changes in their lives (Poll et al., 2006). Since In Control's initial 2006 monitoring, additional research has continued to emphasize the potential benefits of personal budgets. In 2008, interviews with 196 people using personal budgets in 17 local authorities once again demonstrated promising results with participants reported improvement in (Hatton et al., 2008).

This was followed by the publication of the national evaluation of the Department of Health 'individual budget' pilots. While this was a complex study, it nevertheless suggested that personal budgets are cost-neutral and can lead to a number of benefits for service users, such as

> '*mental health service users reported significantly higher quality of life; physically disabled adults reported receiving higher quality care and were more satisfied with the help they received; people with learning disabilities were more likely to feel they had control over their daily lives; older people reported lower psychological well-being, perhaps because they felt the processes of planning and managing their own support were burdens'* (Glendinning et al., 2008, p. 2).

The increase in numbers of personal assistants was also mirrored in the Department of Health funded evaluation of individual budget pilot sites (the review by Glendinning et al., 2008). Although some individuals simply 'converted' their previous care packages into individual budgets, meaning this was predominantly an administrative exercise, others made significant changes to the types of services that they chose to receive.

Several service providers reported that people were leaving their services to be supported by personal assistants and some providers were therefore altering the types of services that they offered. For now, what is important to note is that existing evidence suggests that where people

have been in receipt of individual budgets and direct payments, some have chosen to opt out of existing service providers in preference for employing their own personal assistants or spending their money on different types of services. Moreover, new and different sorts of services can only be delivered if the resource allocation system (RAS) is set at a sufficient level for that local area (ibid, 2008).

Independent living

Independent Living is an initiative a key aim of the disabled people's movement has been to achieve independent living (a situation in which disabled people have as much choice and control over their lives as everyone else). This does not mean doing everything yourself – in practice, no one is truly independent, and we are all interdependent on others to meet our needs as human beings. Such people get care workers to assist them to do the tasks at rates they negotiate (Ferguson, 2007).

Self-directed support

Self-directed support: is the more general term used by In Control to refer to a new system of adult social care. Based around In Control's recommendations (Glasby and Littlechild, 2009), this type presumes that the user has the mental capacity to make decisions about the services that they may require assistance with. They can choose one of the available options and may also defer or increase their care as the needs dictate. For example, one may be able to perform their personal care unaided but may require help with domestic work. They can decide to use their allocated money to hire someone to clean weekly or on a needs basis.

3.3 Salient features of domiciliary care work

Domiciliary care is provided in the home of the client which can be considered the domiciliary care workers 'office' or place of work for the period during which they are undertaking their care provision tasks. The clients (if they have been assessed to have mental capacity) have a say over how and what happens within their home, as do their live-in and sometimes visiting relatives. Unless in instances where supported living services are offered (which will provide an office from which to undertake the administrative and concierge 24 hour services), most of the work performed is within the client's house. The importance attached to the place of work under

domiciliary care stems from the fact that care is a deeply human activity that requires a face to face interaction between the carer and the client because the client is indisposed to meet their care need by themselves (Bubeck, 1995). Therefore, since the client is based in their home the carer must adjust themselves to work in this setting. Though it would be expected that the provision of care within the client's home presupposes ease for the offering of the care, this is sometimes not the case. The home for the client is their personal space, a place where they would ordinarily have a veto about who visits them. In the case of a domiciliary care worker on assignment, the client may have little or no say about who ends up showing up at their door.

Both the domiciliary care worker and the client find themselves in a situation where they are unfamiliar with each other, yet they have to forge a working relationship for the domiciliary care worker's role to be performed. Depending on the nature of care that the client requires, the domiciliary carer may have to enter into personal spaces such as the client's bedroom, take the client to the bathroom or toilet and even also go to the communal areas in case they have to prepare meals or do some cleaning. This finding shows that home carers' encroach into personal space hence a renegotiation of established meanings of bodies and home space may be required (See England and Dyck, 2011).

3.3.1 Episodic working

This refers to the practice within domiciliary care service where the care workers are not paid for waiting time (if they are unable to gain access into a client's home despite arriving on time) and for the travelling time to and in between care visits (Supiot and Meadows, 2001). Similarly, Wills (2003) argued that care workers were only paid for contact time. Contributing further, with regards to domiciliary care work, Bessa et al (2013) argue that unless generally self-employed, a worker travelling for the purposes of duties carried out in the course of their work will be required to be paid at least the minimum wage, excluding the first and last journeys of the day and travel to and from breaks. The UK Government definition of Working Time for all types of work includes time spent by an employee while travelling from one work assignment to another and while on training including travel to the training venue during training. Episodic working has been included in this in this research as the practice is still in use within domiciliary care settings and will be examined based on the stories of the research participants.

3.3.2 Prevalent use of Zero hour contracts

The fastest employment growth in the UK towards the end of the twentieth century was in atypical work, particularly in jobs that are part-time, fixed term or done without a contract (Gregory, 2000). The recent changes within low skilled roles in social care have led to the rise in use of zero hour contracts. This contract is defined as 'an employment contract under which an employer is not required to offer an employee any defined number of working hours and an employee is neither guaranteed any set number of working hours, nor obliged to take any hours offered (Green et al., 2014). Data obtained from the Labour Force Survey (LFS) indicates that figures of those on zero hour contracts rose from 134,000 (0.5% of the workforce) in 2006 to 208,000 (0.7%) in 2012 (Pennycook et al., 2013). However, she argues that the figures are under-estimated as there are 150,000 domiciliary care workers on zero hour contracts.

Domiciliary care has many females working therein. Whether emanating from their child care responsibilities that demand a measure of flexibility or by a decision by their employer to offer them such, a good number of women are on zero hour contracts. Across the care sector 53% of the labour force work part time with 30.5% working on zero hour contracts and the domiciliary care division has upto 60% carers employed under this type of contract (Rubery, Grimshaw and Hesbon, 2015). About a quarter of those on zero hour contracts are full-time students with 80% not looking for another job (Work Foundation, 2013). Arguing whether the situation is out of employee choice, Berger et al (2013) call for employers applying zero hour contracts to sign up to a code of practice where fair allocation of work and access to training opportunities to enable career progression would be guaranteed. Notwithstanding that suggestion, UK studies within the care sector suggest that even minimal standards are ever so often not met and a good number of organizations lack internal infrastructure for job roles, ladders and career paths (Gospel, 2008; Rubery et al 2011).

Hypothetically, when an employee is on an employer dictated zero hour contract and on low pay coupled with no guarantee of the work hours available, they are likely to hold more than one job to buffer themselves against periods of non-employment and this may sometimes be at odds with the shifts available and the quality of care given if they rush through the care to get to other assignments.

3.3.3 Time measured in fragmented units

Time is of fundamental importance in shaping the employment relationship between the care and the service recipient because of the extended and fragmented working time schedules and is a particularly salient factor in in-person services, as they are co-produced with clients in real time (Rubery, Grimshaw, Hebson and Ugarte, 2015). Time affects the quality and cost of service provision, the deployment of skills and work scheduling and 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 and Neysmith, 1996; Needham, 2009). 'In the social care system, time is the key control mechanism, as it is used as a proxy for service delivery to users, for commissioning by Local Authorities, for fee invoicing, by independent providers and for care staff pay entitlements and as the unit of account represents a claim on contestable resources between the service user's needs and the cost of the service provision' (Rubery, Grimshaw, Hebson and Ugarte, 2015, p. 756).

Local Authorities in England view time as a proxy for volume and quality of services, as the 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 common additional fee paid with the flat rate fee. It is implicitly assumed that care staff will not be rewarded for developing skills to provide higher quality or complex care; this is because as the employer normally receive no compensatory fee enhancements during commissioning (ibid. 2013). In their report on fragmented time and domiciliary care quality (Atkinson and Crozier, 2016, p.1) posit *'that no one sets out to provide bad care, but you are dragged to it, dragged into the gutter'*.

Based on the findings from their research on domiciliary care in England, Rubery, Grimshaw, Hebson and Ugarte, 2015, p. 757 commented that

> *'User needs in social care follow an hourglass pattern- high in the early mornings and evenings with some demand at lunchtime. Weekend needs are also often as strong as weekdays. Care services are demanded exactly when care staff's personal and family demands are highest and also extend into conventional and family weekend time. Scheduling to meet user preferences is therefore not possible. Yet, 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 user needs, including continuity of care.'*

This impacts on the work-life balance of the domiciliary care workers and also impinges into the hours they can avail themselves consequentially affecting their potential earnings.

According to a 2012 report by United Kingdom Home Care Association (UKHCA), average local government domiciliary care visits were as follows:

Under 15 minutes – 10%
16 - 30 minutes – 63%
47 – 60 minutes - 10%
Over 1 hour   - 6%

A worrying statistic by UNISON reported that 74% of councils in England offered care visits lasting fifteen minutes or less (UNISON, 2016). Assuming that the visit is for a tea break or for prompting the client for medication, these fifteen minutes even for such care are rushed and impersonal. For example, if the client is not able to eat within the allocated time, then the utensils used may be left dirty in the sink as the domiciliary worker's time is up. Alternatively, the worker may decide to wait (for no extra pay and of their volition) and clean the dishes after the client completes their meal.

3.3.4 Recording of time units

There is contestation on the recording of time units as recorded time may be an inadequate exemplification of actual service delivery, costs of provision, or the time spent in work related activities. 'There is an increasing use of electronic monitoring of care visits, though, in the absence of technologies to increase productivity in care, technology is being deployed to monitor time, primarily to control resource flows to Local Authorities' (Rubery, Grimshaw, Hebson and Ugarte, 2015, p. 757). Commissioning of short care visits combined with electronic monitoring may shape the distribution of resources between Local Authority 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 (ibid. 2015).

Explicating this, care staff may provide more time than that commissioned and paid for if they are reluctant to leave tasks incomplete and finish on their own unpaid time (Aronson and Neysmith, 1996; Baines, 2004). In reverse cases, 'care time may be less than the commissioned time, if staff perform a task faster than specified, or if the user's family unexpectedly and voluntarily takes on some of the care tasks, which may causes staff to lose earning, as the electronic monitoring requires them to spend the commissioned time in the user's home' (Rubery, Grimshaw, Hebson and Ugarte, 2015, p. 757). To fulfil the aim to accumulate capital, private care agencies and homes have resorted to the use of intricate control mechanisms in the administration of caring labour (Diamond, 1992; Lopez, 2006). It has been suggested that an outcome based approach may provide a solution to the over-rigid prescription of time and tasks which has militated against flexibility and responsiveness (Sawyer, 2005). This approach may be an option to the current situation evidenced within domiciliary care provision and may perhaps address the concerns about the quality of care provided. Strict adherence to time measurements as highlighted above is a striking feature in domiciliary and other care related jobs; this claim may be confirmed in the narratives of the research participants.

3.3.5 The care plan

Though the care plan for most purposes and intent is deemed to represent the work of a domiciliary worker; it neither acknowledges the complexities of the work involved nor its multi-layered nature. However, it is premised on direct task related activities without the appreciation of what it is that supports the successful completion of such activities. As a result of this, care converts into a tradable commodity, with domiciliary carers having to continually reconcile the tensions inherent in a care plan which often leave little time to care (Bolton and Wibbereley, 2013).

Steinberg (1999) maintains that the care plan is not a benign document but one that reflects dominant priorities and interests that are never focused on the domiciliary carer, and paradoxically rarely even on the client. It is further portrayed as being theoretically designed in such a way as to enable any carer to care for any client, through performing repetitive generic tasks, irrespective of whether they have or have not worked with the client before (Bolton and Wibberely, 2013). Attesting to this, Aronson and Neysmith (2006); Cohen (2011); Bolton and

Wibberley (2013) describe the care plan as attempting to standardise a task based model of billable time, though in reality it is unlikely that the intimate nature of caring tasks, the variable and complex demands of the client and the domestic setting would support such a simplified approach to the separation of physical and emotional labour. Since the care plan is generic and adjusted to comply with the particular needs of a client, repetitive performance of the itemised care on the part of the domiciliary care worker may alienate them from the work, especially if there is little or no room for discretion. Using psychological contract literature, a transactional contract is likely to be associated with strict adherence and application of the care plan (Rousseau, 1995).

3.3.6 The duty rota

The role of a rota in the micro management of the domiciliary care's time cannot be overstated as the excerpt below demonstrates:

> *'Far from being merely an administrative tool, the rota represents the political economy of domiciliary care work in the way its organisation intensifies the labour process due to funding systems that only pay for tasks completed and not travel between spatially segregated work spaces, nor does it allow for the unpredictable demands made by clients. However, the rota may shape the organisation of care work but it is the care plan that defines the actual domiciliary care labour process' (Bolton and Wibberely, 2013, p. 689).*

Scheduling is further complicated by objectives to promote continuity of user or care worker relationships, which enhances the quality of care as well as the care workers work experience (Francis and Netten, 2004). Rota administration is carried out by the employing agency staff and may be discussed with the concerned domiciliary care worker before final allocation of duties for them to indicate their preference or to confirm availability for the proposed shifts. It often times may be dictated by availability of commissioned hours and sometimes used to deny those employees whose clients have raised a complaint against, work shifts as a form of disciplinary and deterrent measure (Rubery et al., 2015. The importance of the rota is likely to be highlighted in the stories of many of the   research participants; as the rota helps to approximate weekly/ monthly earnings dependent on the shifts available. It also helps to manage and organise workers time especially if domiciliary care workers are engaged in more than one agency. This is because sticking to and performing the allocated times is vital.

3.3.7 Relationships

Care workers employed by clients on personalized services (for example personal assistants and live-in carers are reported to have higher job satisfaction in comparison to those in other domiciliary care jobs (McGregor, 2007). Nonetheless, the role and boundaries are often times blurred and this can lead to exploitation (Manthorpe et al., 2010). In her comparative research on formal domiciliary care in Austria, France, Italy, the Netherlands and the UK, Ungerson (2004) suggested that carers working within the formal domiciliary care system were more prone to having a 'distant and professional' relationship with their clients though this may not be possible for many carers (ibid, 2004). There is an allusion by Aronson and Neysmith (2001) that female workers' sense of moral obligation lends them to provide additional care to their clients, which evinces exploitation of care workers as it is not always voluntary, but often arising out of moral compulsion, even though at times, due to the insecure labour market status, carers are forced to acquiesce to their employers' demands which is prevalent in live-in settings where work has a semblance of an informal, family like arrangement. Findings of a survey by Skills for Care (2013) concluded that working in the care sector can be both gratifying and emotionally draining as many care workers have faced verbal abuse (93%) and a significant proportion physical abuse (53%).

Since social care is intrinsically about the relationships between the carer and their vulnerable clients, the workers may face high risk situations which can be stressful (Burke, 2013). For example a carer may be required to hoist a client who is bedbound to enable them get out of bed. The hoist may jam in the middle of the activity necessitating the carer to revert to pressing the hoist's emergency button to trigger a rapid release, which will hopefully drop the client into the wheelchair which has strategically been placed below the hoist. Per adventure if anything goes wrong, the carer will face disciplinary action. Furthermore, the carer is concerned about the discomfort caused to the client as this is done. Some elderly clients have tender skin which may be bruised requiring filling out the body map, recording this happening in the incident book and be prepared to undergo lengthy questioning by the employer over this (The example is an abridged version of statements from various research participants on health and safety concerns and the tensions these create to the carers).

In their study on retention and turnover in the US, Mittal et al., (2009) found that by far the issue that was voiced most vociferously for leaving a direct care job was the perceived lack of respect. Other similar studies have also highlighted lack of recognition for care work as demotivating staff (Kemper et al, 2008; Hatton et al, 1995). However, despite some of the negative aspects of care work many workers report high levels of job satisfaction (Robinson and Banks, 2005; Lucas et al., 2008), a finding consistent with that by the national survey of care workers (Skills for Care, 2007), which it states that nine out of ten care workers' jobs made them happy even though contact breach and violation was not the object of their research.

3.3.8 Low or minimum wages

Available information suggests that local authority commissioning practices have a negative impact on the terms and conditions of service for care workers (see Cunningham, 2008; Rubery and Urwin, 2011). Local authorities continue to offer low hourly rates, an example being that of between £14-15 against a UHKHCA 2015 calculated rate of £16.70 per hour (Atkinson and Crozier, 2016). It is noteworthy to point out that pay and working conditions in the independent and voluntary sector are dictated by the commissioning framework set by local authorities and the social care budget available. Most of the domiciliary workers are paid minimum wages or in occasional cases slightly above this. Often times they are employed in private sector organizations, which are sub-contracted by the Local Government (Bessa, et al., 2013). The cuts in social care funding has sometimes led to councils drastically slashing rates paid to independent service provider leading to some firms resorting to using ruses to get round the minimum hourly pay (Ramesh, 2013). Care workers attracted a median wage of £7.90 per hour but 40% of them are paid below £7 per hour (Office for National Statistics 2013). The results of an investigation into 183 care providers found evidence of non-compliance amongst 48% of the providers assessed, the highest levels since 2008 (HM Revenue and Customs, 2013). The most common felonies were about deductions from workers' pay and a failure to pay for items deemed to be business expenses resulting in a failure to meet the statutory minimum wages (Ibid, 2013).

A provider survey conducted by Rubery et al., (2011) showed that the main reason for recruitment problems in the independent domiciliary sector was pay; with others being the nature of work, better paid jobs offered by local competitors, transport costs and erratic working schedules. Pennycook (2013) argues that insecure, undervalued and lowly paid workers, whose care provision work is undertaken in short and intensive time slots often struggle to offer dignified care to their clients. The average vacancy rates in England in social care are higher than for all other types of industrial, commercial and public employment (Skills for Care, 2010). A study by Rubery et al., (2011) concluded that though turnover varies across the social care sector, domiciliary care experiences significant problems in attracting and retaining a trained work force. Moriaty (2010) lists low pay levels, low status, and gendered assumptions about the nature of domiciliary care work, unfavourable working conditions and a lack of opportunities for career growth being factors that make the sector unattractive to many indigenous workers. Most of the employees within the domiciliary care sector are designated as care workers with a few others having risen to senior carers through intra-sector movements or after attaining some certificate and experience.

Table 6: Average annual payments per designation within domiciliary care services

	Annual average payment (£- Thousands)	
Designation	2015	2016
Care Worker	14.2	13.9
Senior Care Worker	18.2	15.9
Registered Nurse	28.2	30.1
Registered Manager	28.4	27.1

Source: Adjusted from Figure 16 Average annual pay rates in the domiciliary care sector in England reported in 2015 and 2016 (UKHCA Ltd, 2016, p.37).

Table 7: Annual turnover workforce rates within domiciliary care in the voluntary and independent sector

	% Annual Turnover	
Designation	2015	2016
Care Worker	32.4%	41.4%
Senior Care Worker	12.8%	13.8%
Registered Nurse	20.1%	15.8%
Registered Manager	8.6%	9.8%
Whole sector Total	24.3%	39.0%

Source: Work force turnover rates in the independent and voluntary domiciliary care sector in England in 2015 and 2016 (UKHCA Ltd, 2016, p. 36).

3.3.9 Communication

Communication is a process that involves a meaningful exchange between at least two people to convey facts, needs, opinions, thoughts, feelings or other information through both verbal and non-verbal means, including face to face exchanges and the written word (Department of Health, 2006).The use of respectful language and gestures promotes dignity (Tadd, 2005) and the consistent assignment of workers can improve communication for both service users and the carers to build a positive working relationship (PG Professional and the English Community Care Association, 2006). Getting to know and relating with service users as people with a history, is key to providing person-centred care (Randers and Mattiason, 2004; Owen, 2006, PG Professional and the English Community Care Association, 2006) as older people want to be cared for by staff who are patient, take time to listen to them and do not rush their care (Department of Health, 2006).

According to Likupe (2006) communication problems suffuse work place relationships with tension. Allan and Larsen (2002) indicated that some nurses in their study had difficulties adjusting to dialects and accents and for Withers and Snowball (2003) overseas nurses speaking in their native tongue were alluded to as being antisocial and reprimanded by their colleagues, while a survey on the National Health Service in the UK by Shield and Wheatley Price (2002, cited by Likupe, 2006) submitted that discrimination was rife and may be an entrenched feature

of the National Health service considering 40% of ethnic minority nurses experienced discrimination from work colleagues with 65% encountering significant racial harassment from clients and their families. Elucidating further, negative stereotypes of foreign workers have been identified as contributing to racism and discrimination in the nursing sector (Allan et al., 2004). Research on migrant domiciliary and domestic workers by Anderson (2007) found that employers frequently construct racial stereotypes of carers based on their nationality and indicate a preference for those from nationalities they deem to have submissive temperaments. Research participants often narrated how they were denied access to client's houses on the basis of their skin colour, nationality or even accents (McGregor, 2007).

 Research findings corroborate that migrant workers may suffer some elements of discrimination resultant from language difficulties or cultural misunderstandings and these vary in relation to their country of birth (Cangiano et al., 2009; Doyle and Timonen, 2009). Transnational dynamics affect the quality and type of care provided by migrant care workers as language and other communication barriers can impede the delivery of high-quality care (Brush, et al., 2004; Johnstone and Kanitsaki, 2008; Tuohy, 2002; Xu, 2008). Similarly, cultural differences in care approaches and norms around ageing have been found to affect the transition of care workers from the care system of one country to another (Berdes and Eckert, 2001; Brush et al., 2004; Johnstone and Kanitsaki, 2008; Kiata and Kerse, 2004; Xu, 2008; Walsh and Shutes, 2013) as these aspects are core to the formation of care relationships, they may fundamentally shape the nature of care interactions (Walsh and Shutes, 2013)**.**

3.3.10 Human Resource Practices

In the wider business world some clients can pressurize sub-contractors to adopt best practice and enforce social audit compliance. Within social care and specifically in domiciliary care where there is a mushrooming of private agencies, the reality is that the imposition of cost constraints deters positive human resources (Rainnie, 1989). Commissioning is requiring that not for profit providers meet human resource standards within the existing cost constraints, which has in turn intensified pressures on management (Cunningham, 2008) whereas, though the external environment had promoted internal training, there was no positive impact on other human resources strategies. Research findings from studies in Australia (Harley et al, 2007) and

in England (Atkinson and Lucas, 2013) showed that formal human resource management practices have a positive impact on care worker's attitudes. However, the application of formal policies is often piecemeal, usually operating in conjunction with more informal practices and not indicative of any consistent strategy (Cassell et al., 2002). Conversely, Storey, Saridakis, Sen-Gupta, Edwards and Blackburn (2010) point out that the absence of consistent formal human resource practices is not necessarily viewed as negative, since such informal practices may contribute to high job satisfaction among workers in small firms and establishments.

3.3.11 Training

Training potentially provides for progression with an individual's current employment and has been found to limit the likelihood that lower skilled employees will be 'forced' to alternate between employment and unemployment and make horizontal moves between organizations that do not result in progression in order to sustain employment (Atfield et al., 2011). Recent case study research on improving progression in low skilled jobs in the social care sector has reiterated that currently progression is not widespread, with key contextual factors being flat organizations (Devins et al., 2014). It therefore remains the responsibility of the individual employee to undertake training to ensure their employability (Nickson et al., 2003) and the voluntarism stance on training by the UK Vocational and Educational Training (VET) further exhibits this (Finegold and Soskice, 1988; Hogarth et al., 2009).

Much of the training provided by employers is related to either induction or health and safety as opposed to being for developing skills that might improve productivity or other aspects of employment that could lead to promotion (Wills, 2003). Resultant from research findings it was argued that employers considered training for lower-skilled workers in anything that was not focused on immediate job and task specific skills as disadvantageous as it increased staff turnover and dissatisfaction through raising of unrealistic expectations for instance, with relation to opportunities for progression (Metcalf et al., 1994; Keep, 1994; Green et al, 2014).
Contrariwise, even when opportunities for training are provided, take-up may be affected by a range of factors including: lack of financial support, lack of information about the training available and its potential benefits, family commitments and previous negative experiences of education (Johnson et al., 2009). If the training is provided during the employees own time this is

a significant barrier (McQuaid et al., 2012). Skills for Care ((2013) opines that in meeting workforce specific standards, following the completion of the common induction standards, all carers should be given an opportunity to achieve a relevant level 2 qualification, thereby recommending the Level 2 Diploma in Health and Social Care, but also promoting uptake of apprenticeships in Health and Social Care (Green et.al., 2014). There is very little training, with many new care workers receiving a couple of days shadowing before being expected to work unsupervised (Kingsmill, 2014) which is confirmed through the narratives of participant of previous research. There is a low prevalence of training and qualifications across the care sector and most of it is work based with 69.4 % having undertaken induction training, 37% have no relevant qualification and only 6.7% hold level 4 or above qualifications (Rubery, 2011).

Staff engaged in low-level and poorly paid employment has little incentive to train as there is widespread lack of faith in qualifications due to the absence of a central quality assurance mechanism (The Cavendish Review, 2013). There are many staff inter and intra social care movement by staff but, notably, they are unable to transfer any non -accredited training obtained from one employer to another, leading to a recommendation by the Cavendish Review (2013) that there is an urgent need for a trusted third party to provide standardized verification of training and development to build a strong social care profession. In April 2015, in a bid to try and standardize training within the social and health care sectors, the Care Certificate was introduced. It replaced the existing National Minimum Training Standards and the Common Induction Standards in England (Skills for Care, 2014.)

3.4 Conclusion

This section has discussed social care, including domiciliary care and personalization and reviewed recent research undertaken, in the sector. Provision of social care in England has been undergoing difficult challenges as demonstrated in the literature in this chapter. Therefore, it is not surprising that there are tensions during the physical operationalization of care precisely with regards to the domiciliary care sector from where care is provided in a domestic space. While there is literature on care work in general and domiciliary care work in particular as so far outlined, there is little that focuses particularly on the situation of the migrant care worker and examining their experiences through the psychological contract. This will be further discussed in

the next chapter. There is a gap in the literature in exploring the lived experience of a significant proportion of the care-worker population – that of migrant care workers and that while various 'salient features' of this work have been identified looking at this through a Psychological Contract lens can add something. In conclusion, the narratives of the migrant domiciliary care workers interviewed for this research will offer a first-hand account of the various types of caring they undertake in their day to day work experiences.

CHAPTER FOUR
MIGRANT WORKERS

4.1 Definition of Migrant Worker

A migrant worker is defined as 'a person who is engaged or has been engaged in a remunerated activity in a State which in which he or she is not a national' (The UN Convention on the Protection of the Rights of all Migrant Workers and their Families cited in ACAS, 2012). If this definition is adopted as it bases its definition on national status, it suggested that if an individual gains nationality status in the host country, they should no longer be identified as migrants (ACAS, 2012). The perceptions of the native inhabitants view migrants and how the migrants view themselves may perhaps be elicited from the experiences of the migrant domiciliary care workers interviewed in this research. Another definition uses the term foreign worker to describe someone who works but has foreign citizenship, while a foreign-born worker is anyone born outside the UK including British citizens (Office for National Statistics (ONS), 2009).

The public reference to a migrant is one who is visibly or linguistically distinct from the indigenous people, while other differentiation terms include 'economic migrant' and 'undocumented migrant' which are meant to describe the otherness (ACAS, 2012). On the other hand, Athukorala (1993) defines migrant labourers as all those who migrate for employment reasons including all those who migrate for work, for longer term settlement, and those who are recruited for a contracted period of time. The operational definition of Migrant used by the researcher is **'Anyone who was born overseas and cannot trace their ancestry to any of the territories that constitute the United Kingdom (England, Scotland, Northern Ireland and Wales)'**.

4.2 An Overview on Migrant- workers in the UK

This chapter has been included in this thesis due to the pivotal role that migrant workers play within the domiciliary care sector. There is a sizeable number of migrants working in the UK in various employment sectors. It has been deemed necessary to lay a foundation through available literature on migrant labourers to contextualize the experiences storied by the migrant domiciliary care workers interviewed for this research. Additionally migration is a key issue in this research as it is the process that brought these domiciliary care workers into the UK. Historically, the migration of people has played a significant role in the development of economies and society generally (Chin, 2002). Nevertheless international migration though not a new phenomenon has received increasing public discourse, including linking and identifying low wage migrant workers with a host of social and economic problems (ibid. 2002). Migration policies play a crucial role in shaping the quantitative and occupational variation of the presence of migrant workers (Devitt, 2011).

Suffice to say, labour market policies allow the entry of migrants in the good times but in periods of economic decline they are less welcome (Debra et al., 2002). In the UK despite the earlier immigration policies (Dobson and Salt, 2009) and the more restricted points system to control immigration since 2011, determined migrants have devised ways to circumvent and gain entry as well as to overstay and apply for consideration for other immigration categories (Devitt, 2011). According to United Nations (2010) there were 214 million people living away from their home countries due to globalization (if interpreted from a macro level approach). In 2018 the number is likely to have increased. With such huge numbers in global migration, this study on the experiences of migrant domiciliary workers is justified, as this group is part of the numbers that would constitute the figures on global migration. Often times there are feelings that migrants loaf off welfare benefits and hence are a burden to the host country economy (Chin, 2002) but, it is noteworthy that the migrant domiciliary care workers interviewed for this research earn their living and are in waged employment notwithstanding the challenges they may be encountering as a result of their migrant status.

Migration is an age old phenomenon but the intensity with which it is now being undertaken is what is causing it to be under scrutiny. The dwindling global resources as well as the current political turmoil in countries and regions that were once peaceful and thriving have pushed people into poverty and hardship. The migrant population in the UK today is more varied because unlike 30 years ago when migrants came from commonwealth countries, from Ireland and the US, migrants come from all over the world (The Migration Observatory, 2011). For example, the inclusion of additional states into the European Union has seen a good number of migrants come to the UK from these countries. The expansion of the EU eastwards since 2004 saw an increase in migration east-west by millions of people from the accession countries, thereby presenting a new migration system from the earlier one (Favell, 2008), as it involves the right of movement, low mobility and information costs and the accompanying east-west pay differentials (Luthra, Platt and Salamonska, 2014). Nevertheless, the lowered barriers on international migration (in the case of EU migrants) and economic motives may not be solely responsible for the increase (Massey et al., 1999; Borjas, 1994), but may suggest an expression of more varied tastes and lifestyle choices by those who choose to migrate (Favell, 2008; Gonzalez-Ferrer, 2010; Conradson and Latham, 2005).

Unlike in the past when there was discontentment about Black, Asian and Minority ethnic (BAME) migration, it is now the turn of the European Union migrants to face the wrath of some indigenous Britons. That does not by any means suggest that the BAME's have gone scotch free. They have just been circumstantially overshadowed. Gender and ethnicity/race also strongly mediate citizenship rights and therefore access to state support and welfare benefits which in turn define and shape racial and ethnic differences in the sphere of social reproduction (Cox and Watts, 2002; Mattingly, 2001) and are similarly very important in determining who does what. For example, not only is care work dominated by women, there is often a hierarchy of preference for particular ethnic groups such that women of a particular nationality may be most sought after as housemaids and cooks (Phillipson, 2007; Cox and Watts, 2002).

Parrenãs (2001) argues that migrant women are themselves often only 'partial citizens' and have significantly different access to material resources and citizenship rights compared with native women. Highlighting more subtle differences based on ethnicity and race, Duffy's (2005) work

in the USA illustrates that while white women dominate in nurturing care work (which is better paid and professional), Hispanic women perform mainly non-nurturing reproductive work such as food preparation and cleaning while Black women are generally over-represented in both nurturing and reproductive labour.

The push-pull model of neo-classical economic theory treated men as the prototype migrant, being regarded as decision makers (making both individual and national choices) and breadwinners thereby downplaying the role of women. A large part of new migration is made up of women who have migrated on their own (Morokravasic, 1983). The role that gender plays in the reproduction of national and ethnic boundaries is important in understanding the positions of migrants (Aranda, 2003). It delves into the differences among migrants both men and women not only in terms of geographical origin, but also the differentiated social positions they occupy in host countries.

The share of foreign-born workers in total employment in the UK doubled from less the 7% in the early 1990's to just over 13% in 2009. It is important to clarify that there is no single definition of 'migrant' as nearly half of these foreign-born workers are British citizens, either because they were British nationals born abroad or because they are long-term residents who have taken British nationality (Anderson and Blinder, 2011). Moving forward, by 2011, there were an estimated 1.5 million registered foreign workers in the UK with studies sponsored by the Home Office, the Institute for Public Policy and others arguing that there was a net benefit of £2-3 billion per annum to the UK economy (Craig, 2007) accruing from the active employment of these group 'yet there are some unregistered foreign workers included in the 2011 statistics since the number of non-UK born nationals in employment stood at 2.56 million' (ONS, 2011, p.4).

Obtaining precise figures on migrant numbers within the United Kingdom is not easy but there are various sources that can be used to address the difficulty with different parameters being used to define and aggregate the numbers. For purposes of highlighting the most recent figures on numbers of migrants in the United Kingdom the latest estimates from the Migration Observatory Briefing 2017 were used. Here below is a summary whose figures include all migrants, irrespective of their age and employment status and the data contained therein is derived from the Labour Force Survey (LFS) fourth quarter annual report.

Since 1993, women have constituted a small majority of the UK's migrant population. Figures in 2015 indicate that 52% of the foreign born population was women (Migration Observatory Briefing, 2017). An analysis of available figures on the distribution of foreign-born persons by age (including those aged 0 – 15), youth (aged 15-25), adults (aged 26-64) and retired (aged 64+) suggests that a vast majority of foreign-born people are adults (70.9%), children (9.4%), youth (9.9%) with the retired being 11% (ibid, 2017). According to ONS (2009) half of the migrant arrivals to the UK in 2008 were aged between 25 and 44 years an indication that migrants are generally younger than the working population overall. Estimates from the Labour Force Quarterly Survey (LFS) Q2 2016 state that there are approximately 2.2 million European Union nationals working in the United Kingdom. Out of these 311,000 work in manufacturing, 277,000 in wholesale, retail or repair of vehicles, 243,000 in accommodation and food services, 215,000 in health and social care activities and lastly 210,000 in construction. The LFS data has some limitations in aggregating the dynamics of migrants in the United Kingdom. Firstly, it does not measure the scale of irregular migration, secondly, it does not provide information on asylum seekers and thirdly, it excludes those who do not live in households - for example the travelling community, or others in communal establishments (Migration Observatory, 2017).

Though it is clear there is an increase in the numbers of new arrivals working in low- waged jobs in the UK labour market this cannot be straightforwardly interpreted as a response to a 'labour shortage' (Anderson and Martin, 2011). Elaborating further they argue that there is in fact no universally accepted definition of a labour shortage and crucially the definition of shortage typically underlying employers' calls for migrants to help fill vacancies is that the demand for labour exceeds supply at the prevailing wages and employment conditions; and that most media reports of 'labour and skills shortages' are based on surveys that ask employers about hard-to-fill jobs at current wages and employment conditions (ibid. 2011). The obvious counter to this is that the existence and size of shortages critically depend on the price of labour, and that the shortage can be cleared by employers raising wages and improving employment conditions.

The labour supply available for use by employers includes the unemployed or inactive people as well as migrant workers and is highly diverse in terms of expectations and motivation for participating in the labour market. In their study in the agricultural sector, Anderson and Blinder (2011) argued that a majority of the employers interviewed acknowledged that the wages offered therein would be unacceptable for British workers. Employers use migrant workers either as a complement to the existing workforce as the migrants offer characteristics that are different to the lower skilled indigenous labour force or as a substitute to the existing workforce offering the same qualities as the lower skilled indigenous persons but with economic advantages to the employee over the lower skilled indigenous workers (McCullum and Findlay, 2013). The ways in which migrants are used by employers are shaped by inter-relationships between institutional norms, public policies and social relations (Anderson and Ruhs, 2012). There are a good number of migrant workers from former commonwealth countries as well as others who hail from other parts of the world that may have little historical ties with the United Kingdom. The expansion of the European Union prior to the current Brexit situation has also been a significant source of migrant labourers. The proportion of women among EU migrants is 10% points lower than that of men leading to some arguments that non-EU migration may be a remedy to the excessive 'feminization of the work force' (Cangiano, 2014).

Research on migrants' motivation and employment abroad has demonstrated that they are often agreeable to accept low-skilled jobs in high-income countries at wages and under employment conditions significantly lower than those mandated by local labour laws and regulations (Dench et al., 2006) particularly when a limited and relatively short spell of employment abroad is planned. They sometimes end up staying longer and seeking to regularize their stay and settle for the available jobs which may eventually be permanent. Additionally, research based on employer demand for migrant labour has revealed that employers are typically acutely aware of the economic and other trade-offs that migrants are willing to make by tolerating wages and employment conditions that are poor by the standards of their host country but higher than those prevailing in migrants' countries of origin (Massey et al., 1993; Matthews and Ruhs, 2007) and may exploit this to carve out jobs that attract only migrants. Due to their different frame of reference new migrants may be prepared to accept jobs whose skills requirements are significantly below their actual skills and qualifications creating 'high-quality workers for low-

waged' jobs who may be more attractive employees than available British workers (Anderson et al., 2006; Lucas and Mansfield, 2010). Responses from skilled migrant workers interviewed by Mackenzie and Forde (2009) affirmed that performing low-skill, monotonous work in Britain was seen by migrants from Eastern Europe as a relatively benevolent option compared to the meager wages in post-communist countries, this inferring that freedom of movement came at a price of downward occupational mobility. A study by McGregor (2007) on Zimbabwean carers alluded to similar findings on the exchange rate of the devalued Zimbabwe Dollar against the British pound compensating for the down grading of well -educated and professional migrants now performing jobs in the secondary employment sector.

It has informally been assumed that migrant labour has been employed to meet staff shortages across a range of jobs, including skilled jobs (Bach, 2007; Larsen et al., 2005; Ryan, 2007). However, on the ground labour market experience indicates that migrants are more likely to be engaged in low paying jobs (Curries, 2007, Datta et al., 2007; Piore, 1979) that they are overqualified for in terms of education and experience (Baunder, 2006; Kreyenfeld and Konitzka, 2002, MacKenzie and Forde, 2007) where they perform often monotonous or physically and psychologically demanding work (Fitzgerald, 2007, Holgate, 2005). In short, migrant workers are over-represented in 'bad jobs' (Waldinger and Litcher, 2003, p.9).

For some divisions within the social care sector employers adopt active recruitment strategies to attract immigrant workers already in the national labour markets and sometimes also recruit directly from abroad through recruitment agencies in the potential workers' place of origin (Fellini et al., 2007; Piore, 1997). Cost minimization is also a reason in the preference of engaging migrant workers and employers may readily pay statutory minimum wages' though a few others may opt for higher 'going rates' as this can be offset against considerations like a self-regulating, self-training, self-disciplining workforce (Rodriguez, 2004). It can be argued that it is within the interests of both the state (at individual system level) and the supra-national economic entities. For example, the European Union, to redistribute the labour production costs onto external social systems (ibid, 2004) hence the concerted drives to attract migrant workers in worker deficient sectors such as residential, nursing care and within the National Health Service (NHS).

Policies on labour market regulation also influence migrant workers work experiences (Bach, 2007).Within domiciliary care provision, families and people on personal budgets are likely to prefer to hire migrants instead of native workers as migrants cost less (Bettio et al, 2005; Da Roit et al.; 2007; Ungerson and Yeandle, 2007). Most of the difficulties raised in the demand for migrant labour are embedded in the context of an underfunded system of care provision and an often underpaid employment sector, but, the over reliance on migrant workers is not necessarily the solution (Spencer et, al., 2010). Perhaps further reforming of the care sector would provide a more lasting solution. For example, to cushion against the expansion of temporary work visas, Canada has put in place admission class for live-in migrant workers (Ibid, 2010). To qualify one must have a job confirmation letter from a Canadian employer; a written contract with the employer; successful completion of an equivalent Canadian Secondary School education; at least six months training or at least one year full-time paid work experience in the past three years and a good knowledge of English or French as well as a work permit before entering Canada (Immigration and Citizen Canada (CIC), 2006).

Holgate (2005) demonstrated through her research findings amongst migrant workers in a sandwich manufacturing company in London that grievances over inequities of treatment paralleled a resigned recognition of being in low paid, low status work as structural forces shape migrants' expectations regarding their work experience. Yet it is imperative to recognize that aspirations may change over time (Mackenzie and Forde, 2009). It has been argued that the longer an immigrant stays in a host country, the more their attitudes towards work begin to reflect the habitus of the non-migrant population (Bauder, 2006), though this does not merely reflect a natural process of adaptation but may also be a calculated response to the labour market constraints or opportunities they are faced with (Datta et al., 2007; Parrado and Flippen, 2005).

Fleisschmann and Dronkers, (2010) opined that citizenship does not impact on migrants' labour outcomes. However, this has been contradicted by findings that new arrivals from the European Union traverse the labour market and eventually abandon low-wage jobs if desirable pay and work conditions are offered (Cook et.al. 2011). A study by MacKenzie and Forde (2009) on migrant labourers work experiences showed that low-wage employers felt that when new European Union citizens got 'westernized' they demanded better employment conditions failing

which they moved on. With specific reference to studies of Central Eastern European workers in the UK, Anderson (2010) and Ciupijus (2011) attest that breaking dependence on employer sponsored and government administered guest worker schemes (which are the most commonly used methods of entry into the UK for new entrants) European Union citizenship can help some of the Eastern Europeans to move away from secondary labour market jobs. The willingness to for example accept low pay and low status work diminishes as individuals and migrant communities settle better into the host country and their aspirations converge with those of indigenous workers (Piore, 1986).

4.3 Skill and employer preferences for use of migrant workers

Skill is a very vague term conceptually and empirically as it is socially constructed and highly gendered (Cockburn and Ormrod, 1993) and may also refer to a wide range of competences and qualifications whose meaning in practice is not always clear (Peck, 1996). Some skills are 'credentialised' for example National Vocational Qualifications, professional qualifications and apprenticeships, yet when what is and is not credentialised changes, jobs can shift from being classified as 'low skilled' to 'skilled' and vice versa without necessarily changing their content (Anderson and Ruhs, 2012). According to Autor et al., (2003) to limit skills measure to formal qualifications is problematic as some soft skills such as problem solving, team-working and interpersonal skills are competences transferable across occupations and therefore not specialized. Non-recognition of credentials and work experience obtained by the migrant from their home countries of origin impacts negatively on the labour market and enhances poverty for recent migrants (Preston and Wang, 2003).

Additional research findings by Anderson and Ruhs (2012) established that certain skills may be necessary to ensure a job is done in a way that contributes to a good service experience, rather than to simply complete the task an example being that the quality of care delivered in the social care sector is affected by the soft skills of those providing care as some service users interviewed actively expressed a preference for personal qualities over qualifications (Anderson and Ruhs, 2012). Equally, Skills can also be used manipulatively by employers to control the workforce when they easily shade into a demand for employees with specific personal characteristics and behaviour (ibid. 2012). Employers may find certain qualities and attitudes desirable because they

suggest that workers will be compliant, easy to discipline and cooperative (Payne, 2000; Belt and Richardson, 2005). The fuzziness of 'skill' is further exacerbated by its application to demeanour, accent, style and even physical appearance, at times being applied to situations where a worker 'looks and sounds right' (Wolkowitz, 2006; Warhurst and Nickson, 2007).

As skills soften, these signifiers may assume greater importance for those occupations that have less regulation regarding formal qualifications and in which employers consequently have greater discretion at recruitment and in some cases employer demand for some particular groups of migrant labour may reflect a demand for specific skills or knowledge related to particular countries, including foreign language skills (Anderson and Ruhs, 2012). 'Migrant workers are seen as a hardworking, dedicated, very reliable and punctual, obedient and respectful to authority' (Lyon, 2009, p.26). A research conducted in the United States by Waldinger and Litcher (2003) affirmed the employers' penchant for employing Latino migrant workers as it was assumed they had the right work ethic. Research on this in the United Kingdom is underdeveloped although there is limited evidence of similar stereotyping among employers. The findings from the Slovak and Polish workers interviewed by Cook et al., (2011) suggested that the perception of them being hard working employees is an entrapment which normalizes the culture of long working hours and allows employers to legitimize the intensification of work (Ciupijus, 2011) hence the popularity of their work ethic among United Kingdom employers in the low wage sectors (Mackenzie and Forde, 2009).

The claims about migrant workers' superior work ethic in comparison with that of indigenous workers are with reference to relatively new arrivals rather than foreign born people more generally (Anderson and Martin, 2011). Applying a dual labour market theory approach findings from Priore's (1979) research summarized that migrant workers are typically overrepresented in jobs with low social status, have hard or unpleasant working conditions with considerable insecurity and limited chances of job mobility, with the job being usually performed in an unstructured work environment involving an informal highly personalistic relation between the supervisor and subordinate (Piore, 1979, pp. 17-19). Lack of cultural capital or knowledge of the culture gained through living and working in England may make the job search and application

process daunting even for those migrants who have a good command of English (Hussein, Manthrope and Stevens, 2011).

4.3.1 Polish migrants in Western Europe post accession

This section has been included as it has been considered important in explaining the rushed migration of citizens of accession 8 (A8) to countries they judged as preferred destinations to migrate to. Though the information is based on a study by Luthran, Platt and Salamonska (2014) on Poles in Germany, the Netherlands, London and Dublin, some of the findings may be applicable for other migrant groups from Central and Eastern Europe as well as other migrants who may have taken advantage of concessions in immigration policies by host countries to enter there. Examples include asylum seekers from war-torn countries and descendants of people who have been granted special settlement status. The Polish form a substantial population of the migrant groups that came after 2004. In the UK by 2010 there were 1.5 million A8 migrants within the first five years following the accession (Sumption and Sommerville, 2010) despite some having returned after a short while. According to the 2011 census the number of Polish born adults (16 years and above) resident in England and Wales had risen from 19,000 in 2001 to 466,000 in 2011 (ONS, 2013). The Personal Public Service (PPS) is an identification number required for one to access social welfare services, public services and information in Ireland. Information based on the Personal (PPS) numbers data showed that there were over 500,000 arrivals from the new A8 countries between 2004 and 2010 (Department of Social Protection, 2013). Despite the back and forth migration into Ireland from Poland and back to Poland, the number of resident Poles rose from about 2,000 in 2002 to 120,000 in 2011 (Central Statistics Office, 2012). In Netherlands for example, Polish born persons increased from 2,234 in 2003 to over 13,000 in 2009 (Statistics Netherlands, 2010). Regarding Germany persons stating Polish background was over 1 million out of which 400,000 still retained their Polish nationality (Luthran, Platt and Salamonska, 2014).

Traditionally migration has been framed as a reaction to push factors of unemployment and low wages and to pull factors of tight labour markets (Wallace, 2002; Drinkwater et al., 2009). However qualitative research studies have documented the complex non-economic motivation of the new EU migrants and the intricacy of their migration patterns (see Ryan et al., 2009; Cook et

al., 2011; Burrel, 2010). For migrants from the EU region, the unrestricted access and technological advancements suggest friction-less movements into and intra EU destination countries as it is relatively cheap and easy thereby meaning that the neoclassical cost/benefit calculus are very low (Luthran et al., 2014). There is increased use of mobile phones, Skype and other social media forums of communication (Dekker and Engberson, 2012) as well as cheap flights (Williams and Balaz, 2009). These offer a rich web of trans-national ties that avail information and socio-economic support to potential migrants (Kalter, 2011).

4.4 Migrant Motivations and Typologies

Eade et al., (2007) described the characteristics of Polish migrants in Western Europe as: Stayers- those that permanently emigrate; Storks- those who frequently move back and forth; Hamsters- those who stay in the receiving country with the goal of maximizing savings to bring home and Searchers- those who maintain an uncertain duration of stay. Duvell and Vogel (2006) offered another categorization based on the migrants duration of stay and with specific reference to migrants in UK. These include: Returners, Settlers, Trans-nationals and Global Nomads. Grabowska and Okoloski (2009) identified the following categories from their research: Seasonal; Settling down, Long –term and those with unpredictable intentions.

These studies on migrant motivations and typologies were conducted using qualitative research methods. Using a quantitative sample on Polish migrants in Netherlands Engberson et al., (2013) recognized four migrant types namely: Circular; Bi-nationals, 'Foot-loose' and Settlers.

Migrants are heterogeneous and so there might be a range of motivations for their decisions to migrate. Once they are in the host country factors such as their immigration status (student, on spousal and family reunification visa, refugee /asylum seeker) and ability to have the skills they have acquired in their home countries adapted (for example doctors and nurses) inform and dictate the migrant typologies they will fall into. It is nevertheless crucial to point out that these categories overlap and the range of situations suggested above should be borne in mind considering the situation the participants in this research may be grappling with. Drawing from the literature availed, subsequent sections within this research will hopefully shed light about whether other non-Polish migrants depict similar behaviours.

4.5 Some ramifications of being a migrant

That one was born outside the United Kingdom and that their genealogy/ancestry can be traced to being from abroad/overseas has its own challenges. A review of available literature will explain this further. It would appear that once a migrant always a migrant even after naturalization and sometimes even after obtaining citizenship in the host country. While it is obvious that in the United Kingdom persons of colour would be visible in a crowd owing to their skin colour, treatment of migrants affects even those who are 'white'. This can be both in a positive and negative way. So important is this that the researcher has included literature with specific information about the treatment of Eastern Europe and on 'Whiteness' as a criteria used to perpetuate discrimination of migrant workers. Importantly also, the hardships faced by migrants can be expressed overtly or covertly. Other ethnicities also suffer some indifference that can be attributed to the fact that they are non-indigenous.

4.5.1 A complicated and differentiated employment rights system

The system of employment rights for migrants in the UK is highly complex, with a variety of visas and work permits for different categories of workers and countries of origin, making legal migrant workers unaware of their rights (Craig et al., 2004). In addition to this, the restriction of legal entitlements to work and on migrant workers' mobility has compounded their insecurity and vulnerability to exploitation (ibid.2004). The Civil Penalty Regime that was introduced in February 2008 which granted additional powers to the UK Borders Agency to tackle illegal working have been criticized (Ciupijus, 2011; McDowell, 2009). It is argued that this, together with the points-based system for work and study is making migrant workers more vulnerable to abuse by exploitative employers, and that there is likelihood that this will push some workers even further underground and into the hands of the worst exploiters (Flynn, 2007; Wilkinson and Craig, 2011). Across many sectors of the economy, higher competition for workers and workers' diminished ability to challenge or leave bad employers combine to create real risks of exploitation (Gadow, 2009, p.5). This is among some of the sobering stark realities they find themselves facing at the onset of their integration journey.

4.5.2 Gradations of Whiteness

Theorization of whiteness is a relatively recent development in critical social theory that has until recently been typically assumed to be advantageous in the labour market (McDowell 2009, Ignatiev, 1995). Whiteness is both unmarked and invisible in the West, yet it is a mark of domination and superiority in the construction of racialized hierarchies (Linke, 1999). McDowell (2009) contends that in Western scholarly imaginary, white skin is designated as a discursive construct; unmarked, unseen and protected from public scrutiny hence whiteness is deeply implicated in the politics of domination. Furthermore, when viewed as a location, a space, a set of position from which power emanates and operates, white political practice appears to be thoroughly disconnected from the body and corporality being removed from the politics of whiteness (ibid, 2009). 'Disassociated from physicality Whiteness is perceived as a normalizing strategy which produces racial categories' (Linke, 1999 p. 27).

Some White people are 'socialized to believe the fantasy that whiteness represents goodness and all that is benign and non-threatening' in comparison to the dark skin of 'others' (Dyer, 1988, p.45) and whiteness therefore represents purity, spirit rather than body/embodiment thence (McDowell, 2009). The argument by Anderson (2009) that these sets of association have been crucial in the development of a discursive rather than the essentialized view of ethnicity/race in studies exploring discrimination in the labour market and in other arenas against Britain's non-white population. Research by Bonnet (2000), Dyer (1997) and Frankenberg (1997) suggest a polar dichotomy between Black and White and taken for granted associations of superiority and inferiority, leading to a new research agenda (MacDowell, 2009) 'because until recently, the multiple ways in which whiteness has been politically manipulated, culturally mediated and historically constructed have been in large part been ignored' (Linke, 1999, p.28).

It has been suggested that whiteness is a relational concept rather than a singular unvarying category as is constructed by the way it positions others at its borders, as excluded or inferior (McDowell, 2009). According to Fanon (1967) and Said (1978), it produces both a system of racialized inequality and also within the realms of western representation, a source of fantasy and repressed desires. According to Roediger (2002) there are degrees of whiteness, distinctions within the category that also position 'white' minorities in a hierarchy of acceptability. The

European Voluntary workers (EVW's) used their white skins to achieve an invisibility that was inaccessible to Black migrants who came to the UK almost at the same time and Black citizens found that they were hyper-visible and so subject to surveillance in ways in which 'white others' including EVW's were not (McDowell, 2005). But skin colour, as the Irish in Britain and the USA know only too well (Roediger, 1991), is also mediated through class and religion, age and gender, language and cultural norms, constructing hierarchies of whiteness in the British labour market. Differences among the 'new' European workers may place them in a hierarchy of acceptability, despite their common whiteness. Writing on the whiteness of Bosnian refugees in Australia, Colic-Peisker (2005, p.622) stated,' Clearly whiteness is not just about skin colour, but it is also about class, status, language and other features of the individual that can be discerned in social interaction'.

4.5.3 Attitudes about 'Eastern European' migrants

The fastest growing group of migrants in the UK is from Central and Eastern Europe (Christensen and Guldvik, 2013). In a society riven by racism and marked by discrimination against Black and minority ethnic British- born populations largely on the basis of colour (Solomos, 2003), whiteness is potentially a marker of privilege even at the bottom end of the labour market (McDowell, 2009). Like their predecessors, the new Europeans are less visible because of their skin colour and have a European identity and heritage in common with their host population; nevertheless, unlike the post-colonial migrants who came between the two European migrations, they have no previous connections with the UK and often enter speaking relatively little or no English (McDowell, 2009). There are divisions in the UK public discourse that portray Central European migrants as temporary migrant workers taking jobs from British citizens (McDowell, 2009) with a study of the daily interactions between new European Union citizens and members of established Communities indicating that these group are viewed as also competing for welfare benefit support (Cook et.al., 2011).

Meardi (2007) argued that labour migration from Central Eastern Europe is an exit mechanism from the persistent poverty and inequality and the absence of voice mechanisms thereby compelling many European Union member state nationals to relocate to old member countries. The vision of intra-European mobility as an exercise of citizenship rights is brought into question

by for example the desperation seen in the new European Union member states such as Latvia (Sommers and Woolfson, 2008). Research on low-pay workplaces suggests that the voluntarism of working long hours by Central Eastern European migrant workers is resultant from the low wages they receive and the need to send back money to their home countries. It is unfortunate that the workplace conditions experienced by new European Union citizens –long hours and work-time spent almost exclusively among co-nationals from Central Eastern Europe; do not give time for language learning and social interactions with British citizens (EHRC, 2010, MacKenzie and Forde, 2009).

The socio-legal ambiguity and downgraded status assigned to new European Union citizens reflects the long-standing cultural construction of the people from Central Eastern Europe as being not fully European (Ciupijus, 2011) and their being viewed as a cultural and economic periphery, advantageous in supplying skilled low-cost labour to the centres of western civilization (Burrell, 2009). Some employers have been found to treat Eastern European workers in a discriminatory manner despite their being 'White' (Ciupijus, 2011). Such considerations lay behind the decision to recruit Eastern Europeans research participants, alongside migrants of colour in this research to offer an opportunity to establish if this may be the case with domiciliary care workers.

4.5.4 Manifestations of Racism

Racism is' less favourable or hostile treatment of 'individuals or groups based on perceived 'racial' and cultural differences (Harman, 2010, p.177. Solomos and Back (1996) argue that racism has always been conceptualized in relation to a range of political movements and cultural contexts, making a single definition impossible. However, the common thread is that racism involves an 'attempt to fix human social groups in terms of natural properties of belonging within particular political and geographical contexts and placing of particular groups or individuals as superior in relation to others' (Burnett, 2001). Hancock (2007) similarly argues that experiences of racism are inherently complex, being part of a set of potential factors that intersect. Visible markers such as skin colour are one way in which people are grouped, despite the evidence that such features are not associated with physiological differences (Hauskeller 2006). These features are for example shape and size of the eyes, nose, hair texture type etc.

Cultural differences, too, are an important source of racism (Bowyer 2009). Furthermore, language and skin colour may be used as markers to classify, and negatively evaluate, others' cultures (Johnstone and Kanitsaki 2008), leading to discrimination and racism.

Gawronski et al., (2008) distinguish between 'old fashioned', 'modern', and 'aversive' racism. 'Old fashioned' racism tends to be open and direct and is associated with non-egalitarian beliefs, particularly in the superiority of white people. Modern racism involves negative feelings towards people from different ethnic groups, which persist despite an avowed belief in egalitarianism. The negative feelings are associated with beliefs that discrimination no longer exists and that members of ethnic minorities therefore do not deserve the benefit of special policies that are believed to favour these groups. There is evidence that employers use racial and national stereotypes in their recruitment of migrants to work in the care sector (Anderson and Rogaly 2005; Doyle and Timonen 2009). Meintel, Fortin and Gognet (2006) also found that migrant auxiliaries (home care workers in Montreal, Canada) experienced racism combined with generally negative treatment (being seen as servants, for example) by service users from the same ethnic group and countries of origin in addition to white service users. Racism and discrimination from employers are typically manifested in conditions of service, work allocation, and progression opportunities (McGregor 2007; Cangiano et al., 2009; Kofman et al., 2009).

In the UK, migrants have been found to be more likely to experience racism both in the workplace and in the community (Kofman et al., 2009) than UK nationals from black and minority ethnic (BME) groups. This includes those from Eastern European countries which joined the European Union (EU) in 2005 (the 'A8' European states), as well as other migrants (Stevens et al., 2012). Migrant workers have often been treated as a homogenous group, with little acknowledgement of those people with good English skills or different reasons for choosing to work in social care (e.g., as a general route into the labour market, as a temporary job while studying, as a stepping stone to professional work in the UK, or to facilitate further migration to other developed countries). The literature has also not usually distinguished the experiences of care workers who originated in, for example, the A8 countries, those from the Philippines, India, or countries in Africa. It seems likely that their experiences might be different (Stevens et al., 2012). Finally, migrant care workers, particularly those working in direct care positions, face the

additional vulnerability of working in a low status, low paid, and predominantly non-unionized occupation, which increases the likelihood of being discriminated against and having little redress, and increases reliance on the positive attitudes of employers. Service users, too, tend to be in a powerless position and often in situations of stress or distress, which may result in the veneer of modern racism being peeled back, to allow the old attitudes to be revealed.

Guest and Conway (2002) put forward the argument that there is need to consider national culture as well as organizational culture as we build the analytical framework for the analysis of employment relations in studying the psychological contract. As do Rousseau and Schalk (2000), Thomas, Av and Ravlin (2003) and Wang, Tsui, Zhang and Ma (2003). Cultural differences have sometimes made the provision of social care services either problematic to themselves and to the care recipients. Sometimes it is not sheer racism but cultural differences.

4.5.5 Maltreatment stemming from Ethnicity

According to Anthias, 1990 p.20 race relies on 'notions of a biological or cultural immutability of a group that has already been attributed as sharing a common origin' whereas ethnicity is the identification of particular cultures as ways of life or identity which are based on a historical notion of origin or fate, whether mythical or real. The term ethnicity has been preferred to that of race by some scholars as it is viewed as supposedly having fewer essentialist connotations (Gilroy, 1987). Ashfar and Maynard (1994) however argue that the concept has indirectly endorsed the concept of ethnic absolutism when used in an essentialist way. Ethnicity is also linked to liberal notions of multi-ethnic societies and multi-culturalism may obscure the force of racism due to their emphasis on a benign pluralism (ibid). Anthias (1990) argues that in as much as ethnicity can provide the grounds for inferiorization, oppression, subordination and exploitation, it too may constitute the basis for racism. The example of a White migrant being discriminated or suffering prejudice from other White people be they co-workers or clients may be interpreted to stem from ethnic differences. Whereas, people who may have the same skin colour but hail from different geographical locations and regions or speak different languages, may also practice ethnic bigotry against others. An example of ethnic intolerance is a Black African and a person of Caribbean background othering each other. Sometimes migrants can suffer both racism and ethnocentrism simultaneously for example one from their client and the

other from their co-workers. As this study's sample comprises of persons of diverse races and ethnicities and ethnicity and race may possibly intersect in the migrant domiciliary care workers experiences, new outcomes may be revealed. For example, the research may perhaps shed light on the semantic differences of the two terms (ethnicity and race) during data analysis and interpretation as the research uses Interpretative Phenomenological Analysis and Hermeneutics methodology. It may be likely that a migrant who has suffered a form of discrimination whose reason they are unable to accurately pin-point may form an impression of being unwelcome hence experiencing a sense of not belonging. The section below will further discuss this.

4.5.6 Diminished sense of Belonging

Belonging is about 'emotional attachment, about feeling at home (Yuval-Davis, 2011, p.4) and home is an on-going project demanding a sense of hope for the future. Though home is seen as a safe place (Ignatieff, 2001) it can nevertheless evoke negative feelings on safety with such feeling ranging from being indignant, resentful, angry and ashamed (Hessel, 2010). Belonging inclines towards naturalization and is therefore a part of everyday practices (Fenster, 2004). Even in its most primeval forms, it is always a dynamic process, not a reified fixity and a naturalised construction of particular hegemonic form of power relations (Yuval-Davis, 2011, p.5). Belonging is seen as being multi-layered and multi-site (Antonisch, 2010) or multerritorial (Hammerz, 2002).

Identity is the human capacity rooted in language, to know who's who (and hence 'what's what'). It involves knowing who we are, knowing who others are, them knowing who we are, knowing what they think and so on (Jenkins, 2014). Identification on the other hand is a process not a thing, it is not something that one can have or not, it is something that one does (ibid, 2014). The problem of groupism is that in discussions of identity there is an assumption that identity derives from being a group member. Groups are seen as homogeneous, with gender, class and other categories also seen as groups instead of processes of social relations (Brubaker, 2004).

It is worth commenting that all aspects of differentiation and stratification involve socially constructed boundaries that produce population categories, which are then organized into 'groups'. People in groups are seen as being endowed with a given an inalienable quality thereby

ignoring cross-cutting differences within them. An example is categorizing people as Black, White or Asian. In these categories people have individual differences and may not consider themselves to be in the group you have assigned them into. There is a conflation between identity and culture with identity being used to denote maintenance of traditions and customs. Though the literature presented thus far is about migrants in general, it may be useful in explaining the experiences of these research participants. Do they experience similar or different life experiences in the course of their work? How do they describe or narrate this? Could this influence their individual psychological contract? Does this affect their work performance?

In discussing the constitutive manner of social divisions, Yuval-Davis (2006, p.198) states that,

> '*Social divisions are about macro axes of social power but also involve actual, concrete people [micro axes]. Social divisions have organizational, intersubjective, experimental and representational forms, and this affects the ways we theorize them as well as the ways in which we theorize the connections between the different levels. In other words, they are expressed in specific institutions and organizations, such as state laws and state agencies, trade unions, voluntary organizations and the family. In addition, they involve specific power and affective relationships between actual people, acting informally and/or in their roles as agents of specific social institutions and organizations'.*

Based on this argument, it can then be emphasized that issues to do with social divisions are deep rooted with far reaching effects as they have embedded themselves in such a way that if they have to be understood, one must look at them from a broader view as opposed to the circumstantial ones they may then be projected in.The perceptions about migrants may be impacted by the factors adduced by Yuval-Davis, 2006 and it would be interesting to see if this can be found in the stories of the migrant research participants interviewed in this study.

4.5.7 Migrant Workers and vulnerable work

Within the UK, the term 'vulnerable work' has been explicitly used to describe the employment conditions of migrants against a backdrop of increased immigration during the 2000's (O'Reilly et al., 2010) with the capacity of workers to defend themselves from employers' abuse, being low because of their dependency on a particular employer (Trade Union Commission on Vulnerable Employment, 2008). Industries such as hospitality, care work, domestic services and cleaning as well as security are highly populated by migrants with this type of work often

associated with poor working conditions (long and antisocial hours), low pay, bullying and harassment (Ruhs and Anderson, 2010).

Any migrant whose employment is on a tier 2 visa or below ('skilled' or 'low-skilled') is dependent on a work permit sponsored by their employer, a factor that contributes to their uncertain and temporary status (Anderson, 2010). Despite European Union workers seeming less constrained by their immigration status since their mobility is not regulated by the points based system (Alberti et al., 2013) research has documented how Eastern European migrants from the Accession (A8) countries have continued to suffer forms of discrimination, insecure conditions and poor pay as well as racial stereotyping and skill degradation (Anderson et.al., 2009; Ciupijus, 2011).

Resultant from the neoliberal economic climate over the last few decades and the desire for a better life, there are now an estimated 214 million migrants globally (Holgate, 2012) many of whom are in low-paid unregulated job sectors where they are often segregated from indigenous workers (Milkman, 2006). These types of job are precarious and do not benefit from union protection (Thornley et al., 2010; Wills et al., 2010). Scholars have argued that many of these vulnerable migrant workers work in organizations where the benefits accruing form equality and diversity measures, such as adherence to legislation of human resource management practices are non-existent (Dutton et al., 2008; Lloyd et al, 2008; Lucas and Mansfield, 2010; Ruhs and Anderson , 2010).

Recently migrants are more numerous among 'temps' and 'agency workers' working under more insecure and unprotected conditions, some working illegally in the UK (even those from A8) others from outside the European Union on temporary work permits or are undocumented (Forde et al., 2008; McDowell et al., 2008; McKay, 2008; TUC, 2008). These migrant workers suffer the double disadvantage of being unable to complain for fear of facing deportation and they cannot also enforce their contractual terms because they are illegally employed (TUC, 2008). According to findings from the Commission on Vulnerable Employment, there is high risk of minimum wages breaches, working time regulation, unlawful deductions and chances that inspections by enforcement agencies are 'unacceptably low' (TUC, 2008). McKay (2008)

maintains that independently from their judicial status, recently arrived migrants have generally limited access to legal expertise, collective bargaining and representation through union membership.

4.5.8 Migrant workers participation in trade unions

The change from the statutory sector having a monopoly in care provision to that of a growth in the number of independent and voluntary providers has significantly weakened the role of organized labour. Union membership is virtually none existent in privately run care establishment (Wild et al., 2010). The increasing demand for workforce within the social care provision sector in England coupled with a growth in immigration levels calls for an understanding of the labour force dynamics by business organizations, trade unions and policy makers. Unions the world over have increasingly recognized that in order to protect their members interests and to challenge levels of exploitation it is imperative to draw migrant workers into union membership (Holgate, 2012). During the first quarter of 2011, 38% of all A8 migrants working in the UK were in low-skill jobs with only 7.8% in high-skill jobs and that from 2002-2011 there has been a substantial increase in the number of non-UK born workers in low-skill jobs from outside the European Union (ONS, 2011). There is a growing literature on trade union responses to migration which represents a significant re-orientation of the research agenda in industrial relations (Holgate, 2005; Krings, 2009; Marino, 2012; Meardi, 2011; Milkman, 2006).

Research findings from studies in Ireland concluded that in comparison to indigenous employees, migrant workers work in employments that offer lower pay, job insecurity and uncontrolled work tasks (McKay et al., 2011). Dundon et al., (2007) opine that it is difficult to unionize such jobs as the incumbents may be fearful about expressing displeasure or questioning any work conditions anomalies due to employer hostility. Union membership is higher among the indigenous population and the entry of workers willing or accepting lower wages and poor conditions of work may lead to employers preferring such employees to cut down on costs. This would lead to loss of membership from the existing members who may find it had to obtain jobs or alternatively experience a 'race to the bottom' in terms of wages Dundon et al., 2007; Krings, 2009). Findings from research in the Unites States indicate that union representation

substantially improves the pay and benefits received by migrants with the biggest impact being in the fifteen lowest-wage occupations, where these rose by almost twenty per cent and more than doubling health and retirement plan coverage rates (Schmitt, 2010). Once migrants secure employment and start to participate in the work life of the host society, then social integration and community involvement are likely to follow (Borajas, 1995; Putnam, 2000). Through unionization migrants can establish social relations with indigenous locals at the workplace thereby fostering cultural and economic integration (Valenta, 2008).

Earlier research findings from studies conducted in Ireland found that migrants have fewer opportunities to acquire union jobs due to their limited access to highly unionised public sector jobs (Defreitas, 1993:29). They are more likely to be employed in smaller outlets in the retail and construction sectors hence the low unionization levels in these sectors (Grunell and Van het Kaar, 2003). Even where a union exists, the migrant workers may not be aware of its existence and that they are eligible to join. Language difficulties and limited social contacts in the work place may be some of the reasons for this (Howe, 2004; Fang and Heywood, 2006). Due to their marginalization migrant workers are likely to be vulnerable to employer pressure not to join unions and less likely to speak out against injustices for fear of retaliation (Dundon et al., 2007; Holgate, 2005).

With reference to Ireland, Dundon et al., (2007, p. 516) argue that immigrants have seemingly not been included in union structures and efforts to do so have not had a significant impact on the membership of any of the unions researched. The nationality of the migrant usually dictates the type of union reference. Bargaining over wages and conditions was generally confined to EU and EEA migrant workers while the non-traditional union activities were relegated to be provided to non EU/EEA migrants. There has been soft organizing with attempts to make unions attractive to migrants, through anti-discrimination campaigns, providing free information on employment rights and language training. However, a sizeable number of migrants are not included in these services.

According to Gumbrell-McCormick (2011), contingent work has been growing in Europe in the cause of the last twenty years, thereby challenging trade union structures and their understanding of representation. Due to the triangular configuration between worker, employment agency and hiring company contingent workers require targeted union action (Hakansson et al., 2009). Agency work represents a particularly interesting subject of cross-national research as it raises similar challenges in different union responses across European countries (Ahlberg et al., 2008; Pulginano and Doerflinger, 2013; Bennasi and Vlandas, 2015). Though earlier literature showed that unions have been trying to expand their domain to contingent workers through recruitment and bargaining initiatives (Heery and Adler, 2004), recent research on labour market dualization argues that some unions discriminate against contingent workers, thereby contributing to inequality between their well protected core members and the growing marginal workforce (Bentolila et al., 2012; Palier and Thelen, 2010). The dualization literature by Marx and Picot (2013) emphasizes differences in predilections between non-standard workers (and also the unemployed and women part-timers) and fulltime permanent employment, who primarily shape union strategies (Bennasi and Vlandas 2015) because they 'tend to be more unionized and a more influential constituency' (Rueda, 2007, p.28).

Where unions aim to achieve equal treatment for contingent workers, this strategy is defined as 'inclusion', whilst 'engagement' refers to strategies targeting contingent workers' specific needs (Heery, 2009, p. 431). Unfortunately union inclusiveness towards temporary workers is often measured by the unionization rate, disregarding the collective bargaining dimension (Ebbinghaus et al., 2008). Trade unions consider migrants primarily as workers (a universalistic approach) rather than as migrant workers with particular and overlapping forms of oppressions (a particularistic approach) resulting in a dichotomy between workplace and migration issues, impeding the involvement of diverse and marginalized workers into unions (Alberti et al., 2013).

Unionization/non-unionization of migrants is a topic of interest in this research. Firstly, given that the migrants are considered a hidden population of whom not much empirical research has been conducted on. Secondly, most migrants occupy lower rungs and low pay employments whose wages are determined annually through the National Minimum Wages Guidelines, so, does the union have relevance in such wage matters? Thirdly, do the research participants'

belong to unions given that they have been described in earlier literature as vulnerable and may require union representation during work related grievance and disputes handling? Bearing in mind that the participants are drawn from a cross-section of employment types, how can they be organized for unionization? The psychological contract can be impacted by feelings of breach or violation and may affect employee organizational experiences and behaviour. Literature reviewed under this section is therefore potentially useful for the research.

4.6 Recent studies on migrant care workers

There have been studies on migrant care workers conducted recently. Although some of these findings have been incorporated in earlier chapters to support the literature review, it has been found necessary to pinpoint this in the section below. This shows the importance of migrant labour in the social care sector and the need to understand their work experiences.

Ow Yong and Manthorpe (2016) conducted a pilot study to investigate the experiences of workplace acculturation among 12 Indian migrant carers working in residential homes and caring for clients with dementia. The findings were that the migrants felt vulnerable, insecure and experienced an overwhelming state of cognitive burden arising from the unacquainted cultural context within the first six months of entry into the UK. This was compounded by the fact that they were caring for others who were not members of their immediate or extended families a departure from established Indian cultural norms where people caring for vulnerable persons is done within the family domicile and by family member in contrast with their direct care roles in residential care setups (Ibid,2016). A few participants had been able to utilize their social networks of friends and relatives prior to their employment to acquire the necessary social capital to navigate through this new environment. However after two years of employment they felt better adapted although they felt they required day to day psychological and socio-cultural adjustments. Most of the study's participants who had qualifications from India and were undertaking care roles as they undertook or prepared to undertake adaptation programmes to have their qualifications recognized in the UK, still held on to the hope that their ambition to work as registered nurses within or without the social care sector (Ow Yong and Manthorpe, 2016).

The findings of this research are of significant interest for the current research as there are some differences, namely; though both researches were on workers employed in a division within social care, Ow Yong and Manthorpe interviewed participants drawn from residential care whilst this research was based on persons working within domiciliary settings. Notwithstanding that both research participants were migrants; the former research included only persons of Indian ethnicity while the latter involved participants of diverse ethnicities. Both held face to face interviews with the participants and also used interpretative phenomenological analysis for data interpretation (but the present research added hermeneutical phenomenology in its data analysis process. Finally, both seek to bring out the experiences and perceptions of the research participants about their working life experiences. It will be interesting to see if the research findings of this research on using the psychological contract to explore the experiences of migrant domiciliary care workers corroborate findings by Ow Yong (2013) upon data analysis and interpretation.

Christensen and Gulvik (2013) conducted a cross-national research on migrant care workers lived experiences in the UK and Norway. The study was conducted among 47 participants and focused on cash for care (name used in Norway) or personal budgets (UK). The UK has a liberal welfare state where public accountability for social services is not so extensive thereby allowing the development of a private care market whilst in Norway there is an explicit intent to avoid privatization (Christensen and Gulvik, 2013; Esping-Anderson, 1999). Research findings in both countries established that those highly qualified migrants who undertook care work did the work not as part of their career development, but, saw it as presenting experiences contributing to their personal and professional development. In contrast to the notion 'about low-resource-people who go abroad to improve their lives with the help of work in the home country… surprisingly some of them have a lower or higher university degree or being in the process of achieving one' (Christensen and Guldvik, 2013, p.23).

A comparative study between Italy and the UK on migrants and the marketization of care work was undertaken by Shutes and Chiatti (2012). It is important to note that the two countries have different approaches to the provision of social care for the elderly. Italy follows what can be defined as a more 'familial model of care with high volumes of unpaid care in the family being

matched by cash transfers, to supplement the role of the family (Bettio and Plantenga, 2004; Pavolini and Ranci, 2008). The Nordic countries on the other hand use a 'public services 'model where high levels of care services are provided; while in the UK public provision of social care is 'means tested to determine who qualifies for the entitlement (Anttonen and Sipila, 1996).

Despite these different approaches the finding of Shute and Chiatti (2012, p.392) was that

> *'While the institutional contexts in which migrant care is located may differ, converging outcomes are evident regarding the structural positioning of migrant workers in the provision of care for older people.'*

Findings of a comparative research on the role of migrant care in ageing societies in UK, Ireland, Canada and USA by Spencer, Martin, Bourgeault, Oshea (2010) established that some participants reported aspects of discrimination in relation to wages, working conditions, allocation of tasks and shifts, unpaid overtime, opportunities for training and in execution of disciplinary and dismissal procedures (Spencer et al., 2010). Contrary to hypothetical expectations, the study found little evidence that the admission of migrants in long-term care provision should be prioritized and therefore recommended that future employer demand be closely monitored. In doing so, migration policies be reformed to ensure better integration with those on older adult social care (ibid, 2010). An example worth mentioning is that of Canada where there is a live-in caregiver program (LCP) that allows migrant care givers admission into the country provided they fulfill certain criteria prior and after their admission (CIC, 2006). LCP users increased from about 2,000 in 1996 to 6,717 in 2007 (CIC, 2008). Despite the popularity of this scheme, workers are under-employed relative to their education and some are critical about how their temporary live-in status affects working conditions (Spitzer and Torres, 2008).

4.7 In Summary

Detailed literature has been reviewed on migration, and different aspects on migrants to cover substantial ground in line with the research topic, yet, not losing track of how this relates to the phenomenon under study. Both males and females migrate and are engaged in gainful employment, the motivation to migrate also impacts on the early settlement pattern, including type of job one shall perform. Existing research has shown that it has not been easy for the migrants to integrate into the UK. Even those who have been here for long still have problems

that they grapple with owing to their migrant status which changes to immigrant after naturalization. Even though they may be holding a British Passport (symbol of citizenship) after some time and naturalization, the talk in the street/community areas is 'Where do you come from or 'where were you born and when are you going back home among other overtones' (McGregor, 2007). It has been argued we must acknowledge that just because one arrives into a host country as a migrant does not warrant them to forever be identified as such. It is the degree of acceptance by the wider community that determines whether or not and how long a newly arrived migrant retains their migrant label (McKay, Markova and Paraskevopoulou, 2011).

While initial conceptualizations of the psychological contract noted the importance of culture (e.g., Levinson et al., 1963) contemporary research has largely neglected this influence (Thomas et al., 2003). As a determinant of social exchange in general, research has noted that culture is a primary component in choices people make as to how exchanges occur (Fiske, 1991). Societies place limits on the psychological contract through the level of resources (e.g., skilled labour, capital) made available to firms, and the regulations (laws or customs) that govern acceptable behaviour by both employees and employers (Rousseau and Schalk, 2000). Finally, vilify or celebrate them, migrant workers continue to offer much needed services in the UK and their presence cannot be wished away, so it is important to study them and to examine their experiences. In conclusion in accentuating discussions earlier in chapter 1 , there is still a gap in studies on migrant workers as that there is a growing number of aged persons in the UK; that migrants are heterogeneous with unique work experiences that need to be understood for the maintenance of industrial harmony in the industries within which they work and for social awareness in multi-cultural United Kingdom.This chapter ends the literature review section of this thesis paving way for the next chapter 5, on the methodology used to obtain the lived experiences of the migrant domiciliary care workers interviewed.

CHAPTER FIVE
RESEARCH METHODOLOGY

5.1 Introduction

After the researcher obtained confirmation of admission to study for the doctoral programme, the next challenge was to decide on the most appropriate research design. Some of the parameters used to inform the eventual decision included, the research question (how to answer it); the ethics; the budget available for the research and the time within which this research needed to be completed. The ontology, epistemology and methodology selected may offer an insight on how the researcher addressed the issues mentioned above. Ontology denotes assumptions about the nature of reality, while epistemology refers to the evidentiary assessment and justification of knowledge claims. Methodology is about the process or procedures by which we create these knowledge claims (Chua, 1986; Guba, 1990; Orlikowski and Baroudi, 1991).This chapter deals with the research approach, data analysis through the use of Interpretative Phenomenological Analysis (IPA) and Hermeneutic Phenomenology (HP) and data collection through narrative interviews, ethical issues and a summary.

5.2 The Research Approach

When conducting scientific research, the actions of researchers are steered by the systems of belief through which they generate and interpret knowledge claims about reality (Chua, 1986; Myers, 2009). Ontology denotes assumptions about the nature of reality, while epistemology refers to the evidentiary assessment and justification of knowledge claims. There is no universal unchangeable truth, there are different subjective positions from which humans experience and interpret the world (Peshkin, 1988, 1991) a position that the researcher also holds. The researcher was guided by the view that all meanings are interactively and culturally constructed, with individual social actors being variously located within social settings by gender, class, race, age and other ascriptive characteristics (Ellis and Bochner, 2000).There is therefore no solitary, overriding or static reality, what we have are a host of realities constructed as we interact and dialogue with each other. This fits in well with hermeneutic phenomenology hence the choice to use it in interpreting the meanings of the narratives of the participants in his research.

In a literal sense a paradigm can be perceived as a loose collection of logically related assumptions, concepts or propositions that orient thinking and research (Greenbank, 2003). While applied to the tradition of a qualitative research a paradigm consists of four major components; Metaphysics, Methodology, Quality and Ethics (Ibid, 2003). The metaphysics of a research is constituted of ontology, epistemology and axiology. These considerations determine how a researcher undertakes his/her activities. In reference to the metaphysical ground of a researcher Greenbank (2003, p. 92) argues, 'When researchers are deciding what research methods to adopt they will inevitably be influenced by their underlying ontological and epistemological position. This in turn will be influenced by their values. Ontology is concerned with reality. It is the science of study of being'. The reality can be external to individuals or produced by individual consciousness (Cohen et al., 2000). While applied to hermeneutical phenomenological research reality is perceived as an individual construct dependent on different situations. Hereafter, it is rested on the belief that realities are multiple (Kafle, 2011).

Epistemology is concerned with 'how we know what we know'. It refers to knowledge and the notion that the research work is supposed to make contribution to knowledge itself. According to Hartley (2006) epistemology is the process through which the researcher makes the knowledge claim. Hermeneutic phenomenological research is rested on the ground of the subjective knowledge. As a philosophy of knowledge applied in hermeneutic phenomenology the epistemology is grounded on the belief that knowledge making is possible through subjective experience and insights (Kafle, 2011). In conclusion, the researcher interpreted the stories told by research the participants. The psychological contract is perceptual and therefore subject to various interpretations. This will be discussed further under data analysis when the method of analysis is discussed in detail.

5.3 Quantitative versus Qualitative data analysis

Quantitative methods use a positivistic approach. In the extreme the objectivist approach to social science can see reality as a concrete structure therefore making the pursuit of knowledge about the discovery of what is true and objectively exists in the world (Symon, Cassel and Dickson, 2000). Brewerton and Millward (2001) maintain that the scientists who use a positivist paradigm glean their knowledge from hypothetico-deductive custom by testing theoretically built

models empirically using quantitative means. The emphasis of a quantitative approach is on the quantifiable nature of the phenomenon of interest, to gauge the predictive statistical power, to ensure validity and generalizability of the findings, about an objective, readily apprehended reality (Chua, 1986; Orlikowski and Baroudi, 1991). This approach was neither compatible with the phenomena under study nor with interpretative phenomenological analysis the method chosen for data analysis. Further, the domiciliary migrant workers psychological contract was not being measured. This research applied an emic approach in interpreting the inferred psychological contract based on the narratives the participants gave about their work experiences. However, the experiences as analyzed provide useful information for use in further research on the psychological contract of migrant domiciliary workers.

Having excluded the use of quantitative research methods, next, was to identify a qualitative research design. Symon et al, (2000) argue that while employing the non-positivist tradition a researcher cannot be objective, they should instead be reflexively aware of their subjectivity. The focus of qualitative research is on the interpretation as opposed to quantification, the purpose being to characterize the richly constructed and multi-dimensional social world through the application of a variety of methods for example ethnography and interviews (Cassel and Symon, 1994). Some social scientists have claimed that positivist quantitative methods are many a time inappropriate for use in the study of psychological and social phenomena (ibid. 1994; Symon et al., 2000). Additionally, it is posited that some phenomena are particularly suited for qualitative investigation (King, 2000), given the dynamic nature of contemporary organizational life and therefore not being intelligible from a positivist perspective (Lanisalmi, Piero and Kirimaki, 2000; Rousseau and Fried, 2001).This description appeared appropriate in the seeking to explore the lived work experiences of the migrant domiciliary care workers through the psychological contract. The psychological contract has often been studied using emic and quantitative research methods but the researcher in congruence with (Rousseau and Tijoriwala, 1998; Rousseau, 2001; Conway and Briner, 2005; Coyle-Shapiro, Shore Taylor and Tetrick, 2004) deemed that qualitative research can be helpful in capturing and examining the role of interpretation of the exchange processes that psychological contracting involves, hence the choice of hermeneutic phenomenology to avail a richer and deeper portrayal of the workers' lived experiences.

Since the psychological contract is an important component in this study and based on the referenced arguments, qualitative research methods were found appropriate.

The decision to use qualitative research methods also allowed for borrowing from other disciplines to enrich the research. Other discipline research methods used included those from anthropology, business, sociology and psychology. Qualitative methods clarified the values, language and meanings attributed to the participants in their care roles. The researcher borrowed from research strategies in health services such as the qualitative research undertaken by Strauss (1978) on the process of negotiating in the specification of relationships and roles in health care settings and another by Corbin and Strauss (1988) on the experiences of family members caring for people with chronic illness in home settings. This was useful since the phenomena being studied was the experiences of migrant domiciliary care workers whose work is undertaken in a division within social care services. Further, the use of the qualitative methodology can be justified because it is grounded in a dialogue between the researcher and participant (Denzin and Lincoln, 2000).

Writing about life history and culture Cole (2001, p.126) provided three defining purposes of purposes of life history research as follows:

> to 'advance understanding about the complex interactions between individuals' lives and the institutional and societal contexts in which they are lived; to provide a voice to the experienced life of individuals, especially those voices that may be unheard, suppressed, or purposefully ignored; and to convey individuals' stories through their own words'.

It was the researcher's opinion that though this research was not on life history, the work experiences of the interviewees could be interrogated using a similar approach to that in the anthropological study by Cole (2001). In doing so, the reader is drawn into the interpretive process and invited to make meaning and to form judgments based on an interpretation of the text as it is viewed through their own realities.

5.4 Data Analysis

5.4.1 The General Approach to Analysis

The researcher used an inductive approach in data analysis as suggested in studies such as in (Potter and Wetherall, 2002; Leiblich, 1998; Ezzy, 2002; Pope, Ziebland and Mays, 2000; Silverman, 2000) who deemed this most appropriate for understanding meanings and context of the participants' behaviour, and for exploring their complex experiences, attitudes, values, perceptions and observations about their work. During the first phase of data analysis an inductive emic approach was applied to provide a systematic and rigorous framework for data analysis beginning with individual cases from incidents in the data, developing progressively into more abstract categories with a continual iterative sampling of data to fill in the blanks of the emerging theory. This was in line with using the narrative data to interrogate the first and second research objectives (see chapter 6). This research further, in the second phase of data analysis related the findings to psychological contract literature in a more deductive fashion (refer to chapter 7.

Iteration is 'not a repetitive mechanical task' but rather a reflexive process in which the researcher visits and revisits data, connects them to emerging insights and progressively refines his/her focus and understandings' (Srivastava and Hopwood, 2009 p.77). The purpose of research was to use the psychological contract to explore the experiences of migrant domiciliary care workers in London. The psychological contract was not being measured. Therefore the three ways of measuring the psychological contract namely; content based approach; fulfilment/breach measures and features based measures were not used. The psychological contract inventory as espoused by Rousseau (2000) was also not used. The individual participants were not asked to comment on their psychological contract. They were asked to story their experiences. It is these experiences that the researcher presented in the chapter on intial findings of the narratives (see chapter 6).

Here below are discussions on the main approaches that the researcher used to interpret the data. Grounded theory is discussed as one of the methods through which data analysis could have been conducted. Alternative qualitative methods falling under phenomenology that would have used but were shelved are also discussed. Data interpretation forms the bulk of the findings and discussions and it is therefore a requirement that due diligence be applied when deciding on the

data interpretation method. The choice of interpretation method may have a bearing on the quality of research. The researcher finally decided to settle for interpretative phenomenological analysis as it had been anticipated recruiting a small sample given that the research was not organization based. Although grounded theory was under consideration as a method that would have been used however, because it neither recognizes the subjectivity of the researcher (Charmaz, 2003) nor the researcher's influence on the data being collected (Hall and Callery, 2001) it was considered unsuitable. The description of grounded theory as a 'template for doing qualitative research with a positivist approval' as expressed by Charmaz (2005, p. 509) informed the researcher's decision not to use it.

As a preamble to the next section which sets out the Interpretative Phenomenological Analysis approach used in data analysis the researcher found it necessary to give the reader a background introduction of variant phenomenological methods that can be used for data analysis in studies where human experience is being investigated. A good understanding of phenomenology eases the way to appreciating Interpretative Phenomenological Analysis and Hermeneutic Phenomenology the data analysis methods adopted in this research. Phenomenology is a term encompassing both a philosophical movement and a range of research approaches. The phenomenological movement was initiated by Husserl (1859-1938) as a radically new way of doing philosophy. Later theorists, such as Heidegger (1889-1976), have recast the phenomenological project, moving away from a philosophical discipline which focuses on consciousness and essences of phenomena towards elaborating existential and hermeneutic (interpretive) dimensions (Finlay, 2009; Kafle, 2011). The latter was of use in this research and will be discussed separately. Langdridge (2007) defines phenomenology as a discipline that 'aims to focus on people's perceptions of the world in which they live in and what it means to them; a focus on people's lived experience' (p.4) and further clarifies that phenomenology as a qualitative method focuses on human experience as a topic in its own right. It is concerned with meaning and the way in which meaning arises in experience (Kafle, 2011). According to Merleau-Ponty (1962) the aim of phenomenology is to describe phenomena. Grbich (2007) defines phenomenology as an approach to understand the hidden meanings and the essences of an experience altogether. This is the intended end result of this research, which is to use the psychological contract to explore the experiences of migrant domiciliary workers working in London. 'Phenomenology explores beings how human make sense of experience and transform

112

experience into consciousness, how they perceive it, describe it , feel about it, judge it, remember it and make sense of it' (Patton, 2002, p.104) and focuses on capturing real life contexts through the eyes of the respondents (Gephart, 2004) . First -hand accounts are valuable in providing access to goings-on within work places (Camic, Rhodes and Yardley, 2003; Lansialmi, Piero and Kivimaki, 2004; Locke, 2002). This method allows for flexibility and variation in data collection and analysis as findings emerge (Charmaz, 2006a) hence the researcher's decision to opt for the use of phenomenological methods.

Phenomenological research is a lived experience for researchers as they attune themselves towards the ontological nature of phenomenon while learning to see pre-reflective, taken-for granted and essential understandings through the lens of their always already pre- understandings and prejudices (van Manen, 1990). Heidegger (1976) claimed that what is essential to our understanding withdraws from our rational grasp for control and certainty. In phenomenological research, the researcher is a signpost pointing towards essential understanding of the research approach as well as essential understandings of the particular phenomenon of interest (Kafle, 2011). The researcher's understanding of an essence is always 'on-the way', partial, and particular to the experiences from which the interpretations were formed. There is the possibility, in phenomenological research that new meanings emerge about a phenomenon that draws 'something forgotten into visibility'(Harman, 2007, p. 92).

The challenge of phenomenology is to describe what is given to us in immediate experience without being 'obstructed by pre-conceptions and theoretical notions' (van Manen, 1990, p. 184). There is therefore a need to use the most appropriate methods to reduce this. The Western tradition of phenomenological studies has three approaches namely: Transcendental, Existential, Empirical and Hermeneutical which will be briefly discussed here below.

The basic premise of the transcendental school of phenomenology is its adherence to the notion that experience is to be transcended to discover reality. Husserlian phenomenology is built up around the idea of reduction that refers to suspending the personal prejudices and attempting to reach to the core or essence through a state of pure consciousness (Fireston, 1987; Greenbank, 2003). Therefore, transcendental phenomenology advocates for applying the phenomenological

attitude over natural attitude. The basic interest of this school of phenomenology is to discover and describe the 'lived world'. The research pattern based on this school of thought believes that it is possible to suspend personal opinion; it is possible to arrive to a single, essential and descriptive presentation of a phenomenon. Cohen and Morrison (2000) allude that quite similar to that of the positivist tradition, the advocates of this branch of phenomenology think that if there is more than one reality that leaves doubt and lack of clarity. However there are debates on how to practice reduction. 'Bracketing' and 'epoche' are the terminologies that are associated with this process. But the integration of personal opinion during description differs from scholar to scholar' (Kafle 2011, p. 187). The researcher is of the view that this is an onerous task and was impractical in the manner advocated by Cohen and Morrison (2000) for the purposes of this research and therefore rejected its use.

Next, in this discussion is existential phenomenology in which the theorists share the view that philosophy should not be conducted from a detached, objective, disinterested, disengaged standpoint. They maintain that, certain phenomena only show themselves to one who is engaged with the world in the right kind of way (Warthal, 2006). The ground that keeps it distinct from other schools of phenomenology is its rejection of Husserl's belief of possibility of complete reduction and its firm belief on the attempt to concentrate upon re-achieving a direct and primitive contact with the world. The researcher was of the opinion that this study was not based on ethnography hence found the existential phenomenology method unsuitable.

In discussing the journey of phenomenology towards accommodation as a methodology within the social sciences, Aspers (2004) argues that the pathway has been three pronged- firstly, through a non-empirical type as advanced by Schultz (1962); secondly, through ethnography and thirdly through its eventual integration into mainstream social science. Going forward of this, he proposes a fourth pathway that he terms empirical phenomenology. The approach states that a scientific explanation must be grounded in the meaning structure of those being studied and that the actor's subjective perspective is the starting point of the analysis. Further, it acknowledges the central role of theory in research (ibid, 2004).

The seven steps of empirical phenomenological research are as follows;

1) Define the research question.

2) Conduct a pre-study.

3) Chose a theory and use it as a scheme of reference.

4) Study first-order constructs, bracketing the theories.

5) Construct second-order constructs.

6) Check for unintended effects.

7) Relate the evidence to the scientific literature and the empirical field of study.

The researcher weighed the options of using this approach and concluded that it was not opportune for this research. Some of the steps for example that of conducting a pilot study were considered unnecessary. Aspers (2004, p. 11) asserted that 'the main point of this approach was to ensure that the actor's perspective comes through and thus that no scientific explanation exists unless what is studied is related to the first order constructs of those studied'. Having carefully considered the advantages and disadvantages of above enumerated options, transcendental, existential and empirical phenomenological methods, Interpretative Phenomenological Analysis (IPA) and Hermeneutic Phenomenology (HP) were selected.

5.4.2 Interpretative Phenomenological Analysis

Under this section the Interpretative Phenomenological Analysis and its application in the research will be discussed. Interprtative Phenomenological Analysis is an approach to qualitative research concerned with exploring and understanding the lived experience of a specified phenomenon (Smith, 2004). As a methodology in its own right rather than simply a means of analysing data, It involves the detailed examination of participants' 'life worlds', their experiences of a particular phenomenon, how they have made sense of these experiences and the meanings they attach to them (ibid, 2004). The key theoretical perspectives of Interpretative Phenomenological Analysis are; phenomenology, interpretation (hermeneutics) and idiography (Smith, 2004, 2007; Smith, Flowers and Larkin, 2009). Interpretative phenomenology is a version of phenomenology that does not separate description and interpretation as it draws from the hermeneutic tradition thereby seeing all description as constituting a form of interpretation (Willig, 2008).'Therefore the phenomenological facts of lived experiences are often already

meaningfully (hermeneutically) experienced. Moreover, even the facts of the lived experiences need to be captured in language (the human science text) and this is eventually an interpretative process' (Van Manan (1990, p. 80 cited in Giorgi and Giorgi, 2003, p.168. Interpretative Phenomenlogical Analysis accepts the impossibility of gaining direct access to research participants' life worlds (Willig, 2008). It is characterized as 'an attempt to unravel the meanings contained in accounts through a process of interpretative engagements with texts and scripts' (Smith, 1997, p. 189).

The interpretative orientation of Interpretative Phenomenological Analysis draws on the theoretical perspectives of three hermeneutic theorists; Heidegger, Schleiermacher and Gadamer (Larkin, Watts and Clifton 2006; Moran, 2000; Smith, 2007; Smith, Flowers and Larkin, 2009). They accept that a phenomenon is experienced by an individual in a particular and unique way and yet it is lived within a shared context. Heidegger's position was that human existence is utterly and indissolubly bound up in the world, a world of people, things, language, relationships and culture. Therefore it is impossible for anyone (researcher or participant for example) to opt to transcend or disconnect from these indelible facets of their lives in order to reveal some fundamental truth about lived experience (Larkin, Watts and Clifton, 2006). In this respect, all enquiry starts from the enquirer's perspective, from the basis of their experience. Rather than setting aside or bracketing preconceptions and assumptions in advance of an enquiry, Interpretative Phenomenological Analysis researchers work from a Heideggerian perspective and try to identify their basic understandings of a particular phenomenon but acknowledge that an awareness of these 'fore-conceptions' may not come to light until work has started in the interview or the analysis, for example until the phenomenon has started to emerge (Smith, Flowers and Larkin, 2009). Interpretative Phenomenological Analysis researchers are therefore urged to adopt a 'sensitive and responsive' approach to data collection and analysis that allows the researcher's preconceptions to be prodded and adjusted by the data (Larkin, Watts and Clifton, 2006, p.108). Interpretative Phenomenological Analysis researchers therefore understand that all questioning and interpretation carries assumptions based on prior experience that govern the extent of what can be disclosed.

Consequently the phenomenon can never disclose itself in its entirety and interpretative work is required to understand the meaning of the partial disclosure (Moran, 2000). For researchers this mean that what is captured of another's experience using Interpretative Phenomenological Analysis will always be indicative and provisional rather than absolute and definitive because the researchers themselves, however hard they try, cannot completely escape the contextual basis of their own experience (Larkin, Watts and Clifton, 2006). Of notable significance is to point out that while Interpretative Phenomenological Analysis first found popularity in health psychology, it is important to recognize that it is not a method for health psychology per se and it is now employed in a wide range of areas both within and beyond psychology, for example in health, education, management and the humanities (Smith, 2017). Consequently, the discipline from which an Interpretative Phenomenological Analysis research is being conducted should be considered to avoid bias.

Smith, Flowers and Larkin (2009, p. 37) summarize the co-dependency of interpretation and phenomenology as articulated in Interpretative Phenomenological Analysis as follows; 'without the phenomenology, there would be nothing to interpret, without the hermeneutics, the phenomenon would not be seen.' Interpretative Phenomenological Analysis researchers do not attempt to produce an objective or definitive account of a phenomenon and only claim to access a version of the experience as the participant makes sense of it through their narrative account (Smith and Osborn, 2008). Layers of resistance are met by the researcher in analyzing the narrative for example the hidden meanings, metaphorical references and linguistic signals. The circularity of the process (questioning, uncovering meaning, and further questioning), involved in interpreting and understanding a phenomenon is called the hermeneutic circle (Moran, 2000; Smith, 2007; Smith, Flowers and Larkin, 2009).

Conway and Briner, (2005, p.97) argue that using in-depth interviews produces data of idiosyncratic experiences and interpretations of the psychological contract, grounded in the language of employees and organizational context'. Such accounts are consistent with the psychological contract as a highly individualized subjective construct and because this research is exploratory with the participants obtained through snowball sampling, so Interpretative Phenomenological Analysis fits in well. Bearing in mind the scope of the research, a hybrid of

the phenomenological methods discussed above was applied. Lastly, as the research topic is contemporary but under-researched and given the importance of the migrant workers to the United Kingdom Social Services Sector and the growing importance of the psychological contract in employment relations management, the use of, Interpretative Phenomenological Analysis and Hermeneutic phenomenology (discussed here below) interrogate the topic adequately.

There are some criticisms that have been levelled against the IPA methodology, one is that it relies upon a representational validity of language, but, there are arguments that language constructs rather than describes reality (Willig, 2002). The conceptualization of language in much phenomenological research can be criticized for not sufficiently engaging with its constructive role (Willig, 2007). There is also a concern about the suitability of the accounts. This is because Interprtative Phenomenological Analysis attempts to capture the experiences and meanings associated with a phenomenon rather than to identify peoples' opinions about it. The use of Interpretative Phenomenological Analysis and hermeneutic phenomenology ensured that the short comings in either method as discussed earlier are mitigated. It is noteworthy that unlike the small samples that are often used in snowball sampling, this research had a sizeable number of participants. Though the care sector and particularly domiciliary care has a high population of women workers, in this research a good number of men participated contrary to the initial reservations the researcher had based on the statics available on the low presence of men in this type of job. It seemed desirable to explore the stories of a range of migrant care workers who differed in gender, and ethnicity. To do so would, it was hoped, provide a richer picture of the lived experience of a diverse group of workers.

In conclusion as Bevir and Kedar (2008) discuss, interpretive methodologies encompass an experience-near orientation that sees human action as meaningful and historically contingent. In this view, social science and the subjects it studies are located within particular linguistic, historical, and values standpoints. This contrasts strongly with the drive to identify generalizable laws independent of cultural-historical specificity. Finally, interpretivism focuses on understanding the subjective meanings that participants assign to a given phenomenon within a specific, unique context (Klein and Myers, 1999; Orlikowski and Baroudi, 1991; Walsham,

1993). The homogenization of migrants as alluded to when discussing their issues is one such example, they are a heterogeneous group. To enhance the research, a hermeneutic phenomenological method similar to that used by Svedlund, Danielson and Norberg (1994) in their study on the experiencesof ten women afflicted with Acute Myocardial Infarction (AMI) during their stay at the Coronary Care Unit (CCU). Hemenutic phenomenology is discussed below:

5.4.3 Hermeneutic Phenomenology

Here hermeneutic phenomenology will be discussed as it was used in this research considering that the textual data collected would require a form of interpretation for sense making. Hermeneutics is defined as the theory and practice of the interpretation of the meaning of texts (Rennie, 1999; Cohen 2001). In using this approach the researcher aimed to create rich and deep account of the phenomenon, while focusing on uncovering rather than accuracy. The origin of hermeneutics came about through the interpretation of texts and principally those in the bible. O'dman, (1985); Gustavsson, (2003) and Wangelin (2007) have itemized four important characteristics in hermeneutics;

➢   The Interpretation- which means conveying the meaning of something and for a correct interpretation, one must relate things to their context.

➢   The Understanding- which relates to insight and is dependent on skill and intuition and ultimately requires empathy in order to identify with others.

➢   The Preconception- upon which our understanding is based. It includes prior knowledge, our experiences, our feelings and our value judgement.

➢   The Explanation -a verbalization based on theory that offers an opportunity to revise an interpretation through using dialogues thereby increasing the depth of understanding.

A hermeneutic attitude implies a dynamic process where the interpretation varies as changes between explanation and understanding influence the interpretation. In this research, the 'inductive' analysis phase of data analysis involves the first two of these, followed by the 'explanation' stage that involves the 'explanation' of the possible psychological contract as may be held. To understand scientific interpretation one must see the knowledge and the results as temporary best illustrated by the hermeneutic circle of the interplay between the whole and its parts and between the preconceptions and experiences.

Palmer, (1969, p.43) while commenting on Gadamer's (1960) hermeneutics argues that hermeneutics lies at the centre of modern philosophical problems such as the 'relationship of language to being, understanding, history, existence, and reality'. This was corroborated in the course of data interpretation and analysis as further attested to by Bontekoe (1996, p.123) that' language is central to understanding as it shapes our expectations and our dealings with the things in the world'. According to Koch (1999) hermeneutics is the shared understanding that we come to reach through the medium of language and dialogue. Gadamer (1975, 1981) refers to this as the fusion of horizons. Clarifying this, he states that different interpretations of the phenomenon under study are brought together through dialogue to produce a shared understanding in a professional practice or in a research encounter leading to a bridging between the familiar and the unfamiliar (ibid, 1975, 1981). According to Langdridge (2007), the hermeneutic turn of phenomenology resulted from the opinions that our experiences can be best understood through stories we tell of that experience. To understand the life world we need to explore the stories people tell of their experiences, often with the help of some specific hermeneutic or method of interpretation as were IPA and HP in this research.

Hermeneutic phenomenology by its very name is an interdisciplinary approach that transcends the disciplines and has a very convincing yet distinct set of principles that are essentially targeted to uncovering the better understanding of a phenomenon. As a method within the interpretive research paradigm, it shares quite a number of similarities with other research designs yet it has its own premises and differs from many of them on different footings (Kafle, 2011). Laverty (2003) in his article makes a clear distinction between phenomenology and hermeneutic phenomenology and their historical and methodological considerations. He contends that hermeneutic phenomenology differs from phenomenology in terms of ontological, epistemological and methodological grounds.

Taking self-reflection as the standpoint, Laverty (2003) alludes to the fact that data is to be interpreted using the hermeneutic circle that consists of reading, reflective writing and interpretation (Kafle, 2011). As expected lots of data were collected via the narrative interviews, this proved a logical way of approaching the exercise. Groenwald (2004) mentions some structured patterns of doing hermeneutic phenomenological research. Beginning with locating

the research participants, data collection techniques, data storing methods, data explication strategies and validating and truthfulness, he proposes for asystematic steps for doing phenomenological research.

It has been argued that knowledge is constructed through dialogue; and that meaning emerges through dialogue or hermeneutic conversation between the text and the inquirer (Koch, 1999), with a 'unique characteristic of hermeneutics being its openly dialogical nature: the, returning to the object of inquiry again and again, each time with an increased understanding and a more complete interpretive account' (Parker, 1985, p. 1091). In concluding this, Gadamer (1975) likened 'the metaphor of dialogue with the logic of question and answer' (Koch, 1996, p. 176).

The hermeneutic circle can be described as 'the experience of moving dialectically between the parts and the whole' (Koch, 1996, p.176). In attempting to get a better understanding of the emerging trends, the researcher became part of this circle. It is through the hermeneutic circle that the researcher endeavours to understand 'the whole through grasping its parts and comprehending the meaning of the parts diving the whole' (Crotty, 1998, p. 92) and an examination of the parts thus examining each before it reincorporated into the whole (Bontekoe, 1996). The goal of this type of research is not to clone the texts of the field for the reader of the research but to invite the reader to enter the world that the texts would disclose and open it up in front of themselves (Sharkey, 2001).

In judging the trustworthiness of qualitative research, Guba and Lincoln (1999) have identified four standards namely; credibility, transferability, dependability and confirmability. Confirmability (also known as auditability) denotes the documentation, or paper trail of the researcher's thinking, decisions and methods related to the study (Polit, Beck and Hungler, 2006). The researcher recorded field notes, used memos and a diary, transcripts and also maintained a reflexivity journal. This can allow a reader to follow the researcher's decision making. That notwithstanding, the researcher has elaborated the research process in this chapter. Creditability is another marker of the quality of a qualitative research. It is paraphrased using the descriptions of various scholars as the confidence in the truth value or believability of the study's findings Polit, Beck and Hungler, 2006; Sandelowski, 1986; Streubert-Speziale, 2007).

To demonstrate this firstly, the researcher hopes that the way they present the data is credible to the reader, secondly because of their being explicit reflexivity which helps the reader to gauge any possible influences on the study from their own position. Transferability (fittingness) is about the study findings 'fitting outside the particular study (ibid.2007) and the possibility that the findings would have meaning to another group or can be applicable in another context (Byre, 2001; Streubert-Speziale, 2007). Providing adequate information for evaluating the data analysis and an accurate and rich description of the research finding boosts transferability. On account of its idiosyncratic emphasis, transferability claims to wider populations from IPA study results should be cautiously upheld (Smith and Osborn, 2003). Readers are therefore encouraged to reflect on the personal applicability of research findings, as if the studies are insightful enough, they capture 'what it is to be human at its most essential' (Smith et al., 2009, p.38).

Considering hermeneutic phenomenology as a pedagogic practice of textuality where doing research is to be involved in the considering of the texts that explicate the life world stories of the research participants, van Manen (1997) enlists orientation, strength, richness and depth as the major quality concerns. According to him, orientation is the involvement of the researcher in the world of the research participants and their stories. Strength refers to the convincing capacity of the text to represent the core intention of the understanding of the inherent meanings as expressed by the research participants through their stories. Richness is intended to serve the aesthetic quality of the text that narrates the meanings as perceived by the participants.

Depth is the ability of the research text to penetrate down and express the best of the intentions of the participants. Likewise, Langdridge (2007) proposes for analytical rigor and persuasive account, which this research has strived to achieve. The purpose of validity is not to prescribe the singular true account, but to safeguard the credibility of the final account (Osborn and Smith, 1998). Analytical rigor refers to the attitude displayed by the researcher to pay attention to every case that either confirms or disconfirms the theme. Persuasive account refers to the quality of convincing the reader and its appeal to think about the personal experience for the reader on the light of what he/she has read. To make all these quality claims, what is most important with hermeneutic phenomenological research is to pay attention to the rhetoric because in the rhetoric lies the interpretation.

According to Firestone (1987) rhetoric is the art of speaking and writing effectively. It refers generally to how language is employed. Since hermeneutic phenomenology aims at explicating the core essences as experienced by the participants, the everyday language cannot do justice to express what is intended by the participants. That is why hermeneutic phenomenology demands for a typical rhetoric that best elicit the true intention of the research participants. A language mode with informal tone with idiographic expressions full of adages and maxims is considered suitable for reporting this type of research (Kafle, 2011). Ethical issues are equally important in hermeneutic phenomenology like any other research paradigms. As a qualitative research paradigm, some ethical issues must be observed and practiced while doing this kind of researching. Along with the ethical standards for qualitative research proposed by Creswell (2007) who mentions assigning aliases to the participants to protect their privacy, clarifying the purpose and procedure of the research beforehand, obtaining informed consent and not disclosing the identities of participants.

It places a number of other ethical practices which are to be applied and that includes the strict adherence to the ethics of care, confidentiality and other issues, as required like that of sharing the research findings with the participants. To do a hermeneutic phenomenological research or use its methods as a part of the research methods is an engaging process where the orientation towards the phenomenon is the matter of central concern and its reporting rhetoric demands for a unique richness (Kafle, 2011). Authenticity is how researchers establish that the inferences drawn from are continually valid (Cresswell and Miller, 2000) to ensure credibility in and the eyes of the researcher, the research respondents and individuals external to the study (Charmaz, 2006).The verbatim accounts, vignettes and thick description used in this research attest this. Despite the value of theory in grounding research, organizational researchers seldom test some of the assumptions underlying their theories (Edwards, 2010). This research has focused on examining key assumptions of the psychological contract theory an example being exploring who the other party in the migrant domiciliary care workers is.

By providing rich thick descriptive audio recorded narratives, the researcher has allayed the fears about dependability. Deliberate effort was taken to ensure via the research methods that in telling the migrant domiciliary care workers stories the researcher's voice does not sit above the text.

Bearing this in mind, scholars must consider the role of contextual features that may impact or restrict the issue being studied. The demand for clean research methods does not essentially fit the intricate realities of contemporary work and organizational life (ibid. 2001).

5.4.4 Coding

Three approaches were uded in the analyses of the data.The verbatim transcripts were generated and coded in considerable detail, with the focus shifting back and forth from the key claims of the participant, to the researcher's interpretation of the meaning of those claims. First, was the hermeneutic stance based on inquiry and meaning-making. Analysis was 'bottom-up' with codes being generated from the data instead of using pre-existing theory for code identification. After transcribing the, the researcher worked closely with the text, coding it to get insights into the research participants experience and perception about their world. The emerging codes were then scrutinized to show the recurring patterns. The recurring patterns of meaning (themes) that emerged from the verbatim transcripts showed what mattered to the narrator. Some themes were eventually grouped under much broader themes – 'Superordinate themes' with evidence from the text given to back the themes produced by a vignette, extract or excerpt in tandem with Thomas (2003). A thematic analysis was applied in analyzing the vast data that was collected from the research participants as enumerated in the identification of themes described earlier. It is worth pointing out that at this point the psychological contract types was not a subject of analysis bearing in mind that the participants were not asked to narrate about their psychological contract. At this juncture it is the stories of the migrant domiciliary care workers experiences at work that was analyzed.

Second, was the application of the five steps principles of interpretative phenomenological analysis where the interview transcripts were further analyzed in accordance with the principles of Interpretative Phenomenological Analysis as espoused by Smith, 1995 and Willig, 2008) enumerated as follows:
- Reading and re-reading text leading to wide ranging unfocused notes reflecting the initial thoughts and observations.
- Identifying and labelling themes for each section of the text.
- An attempt to introduce structure into the analysis.

- Relating the themes to each other.
- A summary table was produced bearing the structured themes as well as the quotations illustrating each theme. This table included cluster labels and their subordinate theme labels, brief descriptions and references of where to locate the relevant extracts.

Though most of Interpretative Phenomenological Analysis inspired research stops at the construction of the master themes tables, recent researchers have moved beyond this progressing to more explicitly interpreting the themes (Willig, 2008). In this research, there was a slight modification of Willig (2008) in that the experiences of the workers (from the vignettes that were selected to represent the findings from the narrative interviews) and not the identified themes were explicitly interpreted using psychological contract literature. This will become clearer in chapter 7.

Third, the four important characteristics of hermeneutics as advocated by Gustvsson (2003) and Wangelin (2007) were operationalized (see 5.4.3 paragraph 1). This also helped in demonstrating the quality of research.

In doing data interpretation Eatough and Smith (2008) and Smith (2004) advocate for the adoption of two distinct levels of interpretation, the first a more descriptive, emphatic level whose aim is to allow the researcher to enter the participants world, the other being to critically interrogate the participants accounts in order to gain further insight into the nature, meaning and origin. The latter goes beyond the participants own words and understanding hence being more tentative and speculative. However, though higher levels of interpretation enrich research through generating new insights and understandings, they lead to ethical issues about the imposition of meaning and giving/denying the participants their voice (Willig and Stainton, 2008). This research did not attempt the second level as generalizability was not the goal of this research and that the employees' individual psychological contract type was not being measured premised on their reported work experiences.

Braun (2017) suggested that thematic analysis can be used to analyze large and small data-sets from case study research with 1–2 participants (e.g. Cedervall and Åberg, 2010) to large interview studies with 60 or more participants (e.g. Mooney-Somers, Perz, and Usher, 2008) and homogenous and heterogeneous samples. Virtually any data type can be analyzed, from widely used qualitative techniques such as interviews and focus groups, to emerging methods such as qualitative surveys and story completion (see Braun and Clarke, 2013). Finally, thematic analysis can be used for both inductive (data-driven) and deductive (theory-driven) analyses, and to capture both manifest (explicit) and latent (underlying) meaning (Braun, 2017).

Initially data interrogation and analysis was undertaken through use of computer aided software (CAQDAS) NVivo. This choice was preferred because NVivo can code, sort, query and retrieve data using the Boolean (and/or/not) searches. It was easy to retrieve and simultaneously work through the audio recorded verbatim accounts. The negative effect of using this method is that the researcher may be distanced and alienated from the data, or that this can promote a built in structure for coding and building concepts (Coffrey, Holbrook and Atkinson, 1996 cited in Tracy 2013). However, the combination of interpretative phenomenological analysis (IPA) and hermeneutics in the data analysis mitigated against this. However when the thesis corrections were being undertaken, the researcher relocated back to their country of origin. It was not possible to obtain the NVivo software and this was compounded by the fact that fewer themes needed to be addressed. Having factored in all the inadvertent developments, manual coding was done and a thematic analysis undertaken. The researcher revisited the verbatim interviews to determine the themes were most pertinent to this study. An explanation of the coding process, the identification of the themes and subthemes and the inferred psychological contract is provided (see appendix V and VI).

5.5 Data collection through Story telling   (Narratives)

Narrative research can be considered as descriptive and explanatory (Polkinghorne, 1988) so the use of stories were considered to be in tandem with the objectives of this research. A dominant conceptualization of narrative is that it is one of the many modes of transforming knowing into telling (Mishler, 1986). Commenting on the competing views of narrative, Sandelowski (1990) suggests that it is the paradigmatic mode in which experience is shared and that experience itself

is storied, or has a narrative pattern. In demonstrating the importance and inimitableness of storytelling Polkinghorne (1988, p. 160) argues that human beings are immersed in narrative, 'telling themselves stories in a virtually uninterrupted monologue and tirelessly listening to and recognizing in their own stories the stories of others. This was true in this research as the participants told their story uninterrupted, the researcher on the other hand while listening to these stories recognized their stories in these participants' stories. In story telling not one but two stories are told- the life history of the interviewee as told from their perspective, whilst its reception and re-interpretation by the interviewer is another (Borland, 1991 cited in Gluck and Patai, 1991; Mbilinyi, 1989).

Narratives as data collection instrument are within qualitative research approaches (Gudmundsdottir, 1997). In deciding and selecting the vignettes and excerpts to include in the stories, interpretation and mean making took place (ibid, 2001). Narrative research is an on-going hermeneutic process (Moen, 2006). The hermeneutic cycle sees the story being interpreted throughout the course of the research by both the researcher and the research participants and even after the final report is presented, it now opens for a wide range of interpretations by others who read and hear about the report (Ricoeur, 1981). This is what the researcher intends to set this process in motion upon completion of this thesis by presenting this research in academic journals for critical peer review. This will form the basis of further research and perhaps knowledge creation. Gudmundsdottir (2001) suggested that the stories that occur within narrative research are told and interpreted within a theoretical framework. In congruence with this suggestion, this research made use of the psychological contract as a theoretical framework in the data analysis, interpretation and discussions being careful to main an inductive approach as interpretative phenomenological analysis used in this research demands.

According to Moen (2006), stories cannot be viewed merely as abstract structures sequestered from their cultural content and should be seen as rooted in society, experienced and performed by individuals in cultural settings (Bruner, 1984). Heikkinen (2002) views human knowledge as being a multiplicity of small narratives, local and personal in nature and always under construction. In agreement with this, Bakhit (1986) sees our knowledge as being reliant on our past and present expresses such as our values' the people we are telling the stories to as well as

when and where these stories are being narrated. The experiences in the field while listening to the stories of the research participants confirmed Bakhit (1986) that people always create or hear about a narrative in terms of their backgrounds and life experiences.

Since verbal accounts are the sole empirical data in the narrative approach, they were registered accurately. A small tape recorder was used to reduce the constraints interviewees may feel about use of a recording device (Essed, 1991) and this had been agreed on during the briefing at recruitment and acceptance to participate in the interview. Some participants were at first apprehensive when it was mentioned that the tape recorder would be used. But after the researcher reassured them of their anonymity and the purposes for which this recording was to be used they were agreeable and accept to be audio recorded.

The participants were allowed to tell their story as it is through genuine repetition and storytelling, that humans narrate ways of knowing and being (Young and Saver, 2001, p.80). Use of narrative research was regarded as 'providing a method for telling stories, giving voice to the traditionally marginalized [migrant care workers] by providing a less exploitative research method to afford a more complex and complete picture of social life' (Hendry, 2007 p. 490). To buttress this, Oral narrative, 'reflects a multiplicity of experiences and world views' in that it is a suitable method for understanding the experiences of migrant care workers because of 'their multiple work roles, which are acted out simultaneously'(Ether-Lewis, 1991 p.56 cited in Gluck and Patai, 1991) as they perform their job as carers.

Narrative as an interactive and interpretive product is the focus even prior to its becoming subject to the researcher's purposes, hence the interview and the research report need to be rescued from efforts to standardise and scientize them and be reclaimed as occasions for story telling (Denzin, 1989; Mishler, 1986). Since lives are understood as and are wrought by narratives, narrative approaches to inquiry parallel the ways individuals inquire about experience (Cohler, 1982) and in a sense naturalize (or remove some of the artifice from) the research process (Sandelowski, 1990). This blended in well with the chosen interpretative phenomenological analysis (IPA) and hermeneutics data analysis methods. Therefore, narratives are understood as stories that include a temporal ordering of events and an effort to make

something out of these events; to render, or to signify, the experiences of persons in-flux in a personally and culturally coherent, plausible manner consequently narration is a threshold activity in that it captures a narrator's interpretation of a link among elements of the past, present and future at a liminal place and fleeting moment in time (Churchill and Churchill, 1982). In interpreting the stories the researcher noticed that most participants used the critical incident approach in telling their stories. The facial expressions, the thought process and sometimes the pauses clearly suggested this.

The problem of telling is illuminated when it is understood as the necessity of communicating the seeing- things-together-as –one-thing after another (Polkinghorne, 1988; Rosaldo, 1989). Narratives (like scientific theories) tidy things up- things that in real life may (or even ought to) be left lying awkwardly around (Humm, 1989, p.52).The experience during this research was that participants treated their stories in a manner similar to (Polkinghorne, 1988, Rosaldo, 1989 and Humm, 1989) and could at times return to a part of the story where they felt did not neatly fall into place thereby enriching the story or clarifying what they felt were hanging statements. This made it easier for the researcher during interpretation of the data.

Narration constitutes a kind of casual thinking, in that stories are efforts to explore questions on human agency and explain lives. Secondly, they are historical as opposed to scientific understanding that events cannot be explained except in retrospect. Thirdly, the moral enterprise is that stories are used to justify and serve as models for lives and fourthly, they are a kind of political undertaking in that individuals often struggle to create new narratives to protest the perceived storylessness in the old ones (Freeman, 1984, Heilburn, 1988; Robinson and Hawpe, 1986; Rosaldo, 1989). Individual subjectivity is a concern for marginalized groups since differences can be used as a weapon of self-devaluation by internalized stereotypical societal views, thus leading to a form of psychological oppression (Collins, 1986).

Narrative knowing (Narrative knowledge) is created and constructed through stories of lived experiences, and the meanings created thereby helping make sense of the ambiguity and complexity of human lives Bruner (1986). Knowledge gained in this way is situated, transient, partial and provisional; characterized by multiple voices, perspectives, truths and meanings

Etherington (2008) which is one of the unique contributions of this research. The aim of narrative inquiry is therefore not to find one generalizable truth but to 'sing up many truths/narratives' (Byrne-Armstrong 2001, p. 112). Narrative inquiry is an umbrella term that captures personal and human dimensions of experience over time, and takes account of the relationship between individual experience and cultural context (Clandinin and Connelly 2000). Narrative inquiry is a means by which we systematically gather, analyse, and represent people's stories as told by them, which challenges traditional and modernist views of truth, reality, knowledge and personhood.

Narrative interviewing is understood as a dynamic approach used to generate stories as a data source, stories that help gain access to a participant's actual lived experience (Duffy, 2007). Within narrative inquiry, it is commonly accepted that lived experience is shared by way of a story or narrative (Sandelowski, 1991), and that this basic human expression is seen cross-culturally regardless of ethnicity, language, or culture (Chafe, 1980; Levi-Strauss, 1972). This was confirmed as analyses of the verbatim audio recordings show that the participants had a similar format to the way in which they told their lived work experiences even though they were interviewed independent of each other and a majority of them did not know the other participants in this research.

Narrative inquiry does not seek to find one generalizable truth but it aims to 'sing up many truths or narratives' (Byrne-Armstrong, 2001, p.112).The 'crisis of validity and the 'rights of representation' are some of the challenges a narrative researcher is faced with (Gergen and Gergen, 2003. Clandinin and Connolly (2001).The validity of the narrative told by participants' and whether or not they characterize memory reconstruction or facts is questioned. A social constructionist perspective holds that 'all narratives sit at the intersection of history, biography and society and are therefore dependent on the context of the teller and the listener and are not intended to represent the truth' (Liamputtong and Ezzy, 2005, p. 132). Gregan and Gregan (2003) argue that Foucalt cautioned social researchers to be vigilant to the danger of their explanations and diagnoses after dissemination leading to further subjugation. When one is writing about persons who have been 'othered' there is an inherent risk of sentimentalizing narratives. That is why verbatim extracts help to guard against this.

Some of the challenges faced by the narrative inquiry researcher are the 'crisis of validity' and the 'rights of representation' (Gergen and Gergen 2003). If we accept the belief that there is no one 'truth' and that narratives are co-constructed between the participant and the researcher in a particular social, cultural, and historical context, this raises issues about the sense in which the research findings can be seen as valid and whether or not the researcher can legitimately represent the research participants. Fine (2003) brings to the attention of the qualitative researchers that they need to acknowledge their own power as they conduct research to help the 'other'.

The narrative inquiry approach further, inevitably leads to questions about the validity of the narratives told by participants, including the question of whether or not they represent memory reconstruction versus 'facts' (Clandinin and Connolly 2001). Notwithstanding all the challenges by using the narrative inquiry the researcher was able to surpass the search for one grand narrative as well as to scrutinize the transformative progress of storytelling (Grbich, 1999).

As a narrative researcher the researcher apprehends stories as a way to share experiences with others, to give meaning and gain and build understanding, and to influence compassion toward others in our world, consistent with Engel, Zarconi, Pethtel, and Missimi (2008). Acknowledging that we can never access the direct experience of another, we try to get as close as possible and rely on a story teller's retelling of their experience, as happened during conducting interviews with migrant domiciliary care workers to understand their experiences and to situate this in the context of the variant forms of the psychological contract since '… knowledge is constructed in the everyday world through an ordinary communicative act – storytelling' (Riessman, 2008, p. 14). The researcher's role was to interpret the stories in order to analyse the underlying narrative that the storytellers may not be able to give voice to them (Frank, 2000 p. 4 cited in Koch, 1998).

The researcher's intent in pursuing narrative research for this doctoral research was motivated by a desire to apply a fulsome methodology whose emphasis is interviewing and resonates with them, one who has previously worked as a domiciliary care worker and being of migrant origin. In doing so, a case centred approach has been used as suggested by Riessman (2008) owing to its emphasis on the dialogical, performativity and social aspects which I have seen being interplayed within the research interviewing. From the experiences in the field, the researcher concurs with

131

Van Manen (2002) that story telling served as a means to wade into the darkness of the migrant workers lived experiences. Through narrative inquiry the researcher was able to surpass the search for one grand narrative as well as to scrutinize the transformative progress of storytelling consistent with Grbich (1999). The limitations of narration do not affect the findings of this study as the study does not concern itself with generalizability but in using the thick descriptions used by the participants to describe their work experiences. At the point at which the narration is being done, the contents of the story are real to the narrator. A look at their demeanour for example animation, a pained look, staring as they try to get the right words to express what they are saying are some of the examples. This was a consideration in deciding not to explicitly ask the participants to define their individual psychological contract in line with interpretative phenomenological analysis research requirements.

In summary, the responsive interviewing model was adopted with the researcher being responsible for building reciprocal relationship, honouring interviewees with unfailing respectful behaviour, reflecting on own biases and openly acknowledging their potential effect and owning the emotional effect of interviews is suitable for this type of research (Rubin and Rubin, 2005). A life history, or self-story, or any personal account is still a story, a representation of a life at a given moment rather than the life itself. Moreover these representations do not simply represent, but rather (re) construct lives in every act of telling, for, at the very least, the outcome of anyone telling is necessarily a re-telling (Sandelowski, 1990). In the absence of an ethnographic research, the researcher maintains that the use of narratives was the closest one could get to understand the working experiences of domiciliary migrant workers. Finally, Humans are drawn to story through their residence in narrative life (Lewis, 2001) and as anticipated, this method allowed the respondents to freely discuss their experiences in reliving their psychological contract through their stories on their lived working experiences even unknown to them.

5.6 The Participants

The participants were international migrants working in a cross section of care agencies/providers. A handful of prospective participants who represented maximum variation and met the research specifications were approached and asked to recommend others known to them meeting the selection threshold. The snowball sampling design was applied as it is applicable for use in reaching rather difficult to access populations and is well poised for investigating organic social networks and marginalized populations (Noy, 2007). Though domiciliary care provision is a huge industry, it is hard to find the workers who work therein because they are not organized alongside lines like those in residential or nursing homes or even in the National Health Services. In these surroundings one can approach an employer and get audience or information to the employees in one setting. Some of the former co-workers of the researcher during the period 2008-2009 within which they served as a domiciliary care worker also provided links to those who eventually agreed to participate in the research. Systematic purposive sampling ensured the avoidance of over-proliferation of one migrant group. In total forty four (44) interviews were conducted lasting between forty five minutes to one and a half hours each. Thirty (30) females and Fourteen (14) males were interviewed. They were migrants originally from Africa, Asia, Asia Pacific, The Caribbean, Central America and countries within the European Union member States though a good number of them have since gained British Citizenship.

Interestingly, even those whose citizenship status is now British described themselves in their stories by identifying with their country of birth, culture and traditions. Within the sample interviewed for this research there are three interviewees who work both as direct domiciliary care workers but also have another employment in supported/assisted living schemes. These types involve a situation where a person who had been previously either hospitalized, sectioned under the Mental Health Act or for whatever other mental related issues needs to be rehabilitated and assisted to develop life skills to enable them return back to the community. It is like a placement where Social Services, the National Hospital Services, the Local Authorities and other related partners work in collaboration to assist these types of services users. Independent sector providers are subcontracted by the local authorities to provide mental health support as well as living skills support. The employing entity maintains an office in the same building where these

client groups are individually housed, independent of each other but could share the same support workers. In this type of domiciliary care the client is expected to be encouraged to do their stuff for themselves, getting support if necessary and for instruction with a view of them learning and later on moving on into independent living. This support workers' have the benefit of interacting with their co-workers on a day to day basis as they operate from an office setup when doing the administrative tasks like preparing care plans, risk assessment reviews, maintaining client's diaries and have an on call manager to confer with if they work outside office hours.

In the case of those working under supported/assisted living schemes, depending on the size of the employing entity, procedural human resources management practices may be applied minimally. Support workers do not provide personal care for this client group, they are trained to administer and prompt medication, assist the clients with services that the client may initially need support with prior to their being assessed as able to leave the placement and to progress into independent living. The employer of these workers is registered under the Care Quality Commission as providers under Supported Living Services and therefore liable for inspection. The researcher decided to include these participants as their stories can contribute to suggestions of how the domiciliary care sector can be regulated with reference to the outcry about the poor quality of care and standardization as currently provided. They also were an evidence of the intra sector movement that is practiced within the social care services something that formed part of the storied lives of a number of the research participants.

One of the respondent's whose voice is heard here was a migrant but was currently not serving as a domiciliary care worker at the time in which she was included in the interview sample and referred to as Kelechi. The researcher decided to include her based on the respondent's former experience as she worked as a domiciliary care worker when she migrated into the United Kingdom. She has had a chequered career within the social services sector rising from a Domiciliary Care Assistant, through various managerial positions within the social health care industry, to her most present current position as an Inspector with the Quality Control Commission. The researcher bumped into Kelechi when she was in the field trying to commence the snowball sampling research technique. She was referred by her sister in law who is a

domiciliary care worker. She told her story about the time as a Carer in different junior positions retrospectively. Being a migrant who had succeeded and made a career, the researcher found her experience to be informative. She also is an inspirational story that even another migrant domiciliary carer can arise and shine. The researcher knows only too well that once a Carer always a carer (at heart) even when you move into something different.

Despite the researchers initial apprehension that the snow ball sampling method would yield a small sample, the field experience was pleasantly different. Through referral and contacts from co-workers the researcher had encountered in the stint as a domiciliary care work, forty four (44) participants were recruited. It is important to point out that with each new interviews information and experiences not expressed in previous interviews (it is important to note that the researcher listened to and transcribed every interview after the interview session since it was recorded emerged. The enthusiasm of the research participants in telling their story is acknowledged. Since interviewing and transcribing was done simultaneously, the researcher was able to know the saturation point at which no new information was forthcoming. Thirty females and fourteen males were recruited. Specific information about these participants based on their country of birth and the number interviewed based of country as well as their gender is presented below.

Table 8: Participants Country of Birth, Number of participants per country and Gender

Participants stated country of Origin at entry into domiciliary care	Number of Participants	Gender	
		Male	Female
Nigeria	6	2	4
Zimbabwe	2		2
Kenya	3	1	2
Tanzania	1		1
Cote d'Ivoire	1		1
Cameroon	1		1
Guinea	1		1
Sierra Leone	1		1
Egypt	1	1	
Pakistan	3	1	2
Bangladesh	5	1	4
Philippines	4	1	3
Romania	1	1	
Poland	1		1
Lithuania	2	1	1
Latvia	1	1	1
Spain	2	1	1
Italy	2	1	1
St. Lucia	2		2
Belize	1		1
Antigua	1	1	
Barbados	1	1	

Table 9: Basic participant demographical information

Pseudo name	Marital Status	Country of origin	Region	Years lived in UK	Cumulative Care work experience
Omoyotosin	Married	Nigeria	West Africa	7	6
Okoronkwo	Married	Nigeria		8	5
Kelechi CQC	Married	Nigeria		13	*12
Chiamaka	Married	Nigeria		10	7
Kemi	Married	Nigeria		13	13
Bimbola	Married	Nigeria		9	6
Alayna	Single	Cote d'Ivoire		8	4
Saifatou	Single	Guinea		12	10
Balkissa	Single	Cameroon		5	4
Salieu	Married	Sierra Leone		10	5
Murage	Married	Kenya	East Africa	17	10
Awinja	Married	Kenya		20	15
Nasra	Married	Kenya		4	2
Hidaya	Single	Tanzania		7	4
Zandalinalani	Married	Zimbabwe	Southern Africa	12	8
Musim	Married	Egypt	North Africa	6	2
Dominykus	Single	Lithuania	Northern Europe	7	7
Austeja	Single	Lithuania		5	4
Gustavas	Married	Latvia		9	8
Lizabeta	Single	Latvia		8	7
Lonut	Married	Romania	Central Europe	10	6
Livia	Married	Romania		8	5
Wiktoria	Single	Poland		5	5
Guiseppe	Married	Italy	Southern Europe	10	7
Venetia	Married	Italy		5	5
Iker	Single	Spain		2	1
Sophia	Single	Spain		3	2
Abhik	Married	Bangladesh	South Asia	2	1
Ishita	Married	Bangladesh		3	2
Priyanti	Married	Bangladesh		7	3
Kalpona	Married	Bangladesh		20	15
Shema	Married	Bangladesh		10	6
Ruwaihim	Married	Pakistan		3	2
Farzana	Married	Pakistan		9	5
Jamila	Married	Pakistan		5	4
Angelo	Single	Philippines	Asia Pacific	3	3
Chaya	Single	Philippines		5	5
Isla	Married	Philippines		12	11
Astrid	Single	Philippines		10	5
Sekyeda	Married	St. Lucia	Caribbean's	20	15
Zanda	Married	St. Lucia		35	19
Jenson	Married	Antigua		40	17
Darelin	Married	Barbados		10	9
Cheyenne	Single	Belize	Central America	5	4

In conducting a qualitative research such as this, researcher felt the need to present information showing evidence of having ascribed pseudo names to the participants for anonymity, provide information about their marital status, their original place of birth, the years they had resided in the UK and the number of years they had performed care work. This may help in addressing the proliferation concerns attributed to snowball sampling, and demonstrates a fair distribution of the participants hence reliability of the data collected. **Table 9** is indicative of this.

The researcher used a range to obtain data on the age of the participants. The decision to opt for a range as opposed to asking the participants to state their actual age was based on the researcher's acknowledgement that most of the research interviewees were likely to be women and as the adage goes' you do not ask a lady how old she is.   The data on age is important as it provides an indication of the age mix amongst the migrant domiciliary carers interviewed. The age of the participant and the number of years they have worked in the care industry presented interesting findings in their sentiments about their work experiences. The information about the age of the migrant domiciliary care workers interviewed is useful for comparison with research findings about the age of migrant carers in overall social care sector in in England (see Franklin and Brancati (2015) and Skills for Care (2014).

Table 10: Participant age range, gender and number interviewed

Participant's Age Range	Gender	
	Female	Male
18 – 25 years	7	3
26 – 34 years	19	5
35 – 44 years	4	1
45 – 53 years	8	4
54 – 60 years	2	1

This lengthy exhibition of the sample seeks to address the 'trustworthiness'' requirements. This being research that used stories as the data collection instrument, the researcher found it necessary to adduce that as much evidence as possible to demonstrate that quality research was

undertaken researcher in requirements of conducting quality research alongside recommendations by Guba and Lincoln (1999).

Justification for use of a large IPA sample

Mindful of the established traditions of IPA studies, the researcher has added this section to engage the reader and others who would be interested in the conduct and findings of this research to offer explanations about the decision to use a large sample in this study. Recalling that IPA is situated within qualitative research some examples of studies undertaken as well as one using IPA is provided. In doing so the researcher hopes to allay the jitters that may be in the mind of a stickler to IPA sample sizes that this research is credible.

According to Smith and Osborn (2003, p.54) sample size depends on a number of factors and there is no 'right' sample size. Though infrequent, large samples can be used in IPA studies. This is not unprecedented an example being a study by Clare, Rowlands, Bruce, Sun and Downs (2008) which examined the experiences of eighty (80) women and men living with moderate to severe dementia in residential care. Researchers contributing to a paper by Wagstaff, Jeong, Nolan, Wilson, Tweedie, Phillips, Senu and Holland commented that the small sizes in IPA is repeatedly queried by non-qualitative researchers, and poorly understood by research approval committees who may even consider the research as a pilot study to be expanded later (Wagstaff et al., 2014). With regards to sample sizes used in qualitative studies scholars have found the following tendencies; for studies on ethnography and ethno science, 30-60 (Bernard, 2000 p. 178); grounded theory, 30-50 (Morse, 1994 p.64), phenomenological, 5-25 (Cresswell, 1994 p.64), Bertaux (1981, p. 35) using figures from Guest et al, 2006 quoted 15 as being the smallest number. However these authors do not present empirical arguments for these numbers (Cassidy, et al., 2011). Charmaz (2006. p. 114) advocate for 25 participants for smaller projects with Ritchie et al (2003, p. 84) advocating for samples of under 50.

Thomson (2004) reviewed 50 research articles accessed via Proquest (ABI) Inform with the search parameter grounded theory in the citation and abstract. Findings were that sample sizes ranged from 5 to 350. It was observed that 34% used samples of 20-30 and 22% used over 30 similar to recommendations by Cresswell (I998) and Morse (1994) respectively. Leech (2005)

postulates that is inaccurate to presume that all qualitative research must inevitably use small samples as this disregards a growing body of research studies that utilize text-mining (for example Powis and Cairns, 2003; Del Rio, Kostoff, Garcia,Ramirez and Humenik, 2002 and Liddy, 2000). Text-mining is the process of collecting data from text, clustering it in blocks and identifying the interesting issues, assessing them, categorizing and identifying patterns (Leech, 2005). Though this study did not use text-mining, future IPA studies may use samples considered to be large samples and yet be within IPA conventional practice.

Consistent with the idiographic approach, small samples are commonly advocated for IPA studies (Smith, Flowers and Larkin, 2009; Smith and Osborn, 2008) and an increasingly strong commitment to n = 1 studies has been encouraged (Eatough and Smith, 2008; Smith, Flowers and Larkin, 2009). However, in a 2006 critical review of IPA, sample sizes ranged from 1-35 with most studies falling in the middle of this range (Brocki and Wearden, 2006).Though studies undertaken using IPA often use small samples, this research had 44 participants as the intention was to provide voice to the migrant domiciliary carers who wanted to tell their story. This exploratory study sought to address the knowledge gap and to generate research interest in the experiences of the migrant domiciliary care workers and psychological contract construct. Through using a relatively large sample size for an IPA study, the researcher was able to provide thick description through selected excerpts of the verbatim interviews with the research participants. On a personal level, the researcher wanted to avail an opportunity for the migrant domiciliary care workers to express themselves in their voice and that the researcher was a conversant associate with this group may have led to the large sample size to ensure representativeness of the migrant demographics. The use of a large sample neither affected the quality of the research nor departed from the conventional understanding on how to undertake an IPA themed study as enumerated above.

5.7 The research Location

The focus of study was exploring the work experiences of migrant domiciliary workers in London through the medium of the psychological contract using an emic approach. The research participants included forty four (44) migrant workers providing services in the domiciliary care sector within London. London was selected as it is often a first port of call for new immigrants

before they disperse to other locations and it also has a large number of immigrants working in care provision. The multi-cultural mix of the London population was deemed to be favourable in providing participants of diverse ethnic backgrounds to enrich the research findings. The largest concentration of non- British born care workers is in London, followed by the South East, with Northern England having the lowest percentage (Skills for Care, 2012). There are however 18% non-British born carers in West Midlands (Green et al., 2014). A study in London therefore sampled the views of a cosmopolitan population of the migrant domiciliary care workers.

The researcher was based in London so the logistics of organizing interviews best suited venues within London. These participants included students on study visas with twenty hours a week working eligibility, dependents of migrants who are allowed to work in the UK and those who came mainly to find employment in the UK. The researcher did not delve into matters pertaining to the immigration status of the migrant domiciliary care workers. It was assumed that since the care sector is still regulated as it offers services to vulnerable populations, the Data Barring Services (DBS) and other impromptu home office checks make it hard for illegal workers to find employment in this sector. Fourteen male and thirty female migrant care workers working in domiciliary care within London were interviewed.

Age, educational status, ability to speak English was essential (as no translators were used and to interpret the stories a good level of English was demanded) of the interviewee to make it easier for the researcher to form an understanding. The marital status and race did not infringe on a participant's eligibility to engage in the research as long as they met the general criteria (migrant, domiciliary care worker and working within London). The participants were interviewed at agreed venues which included open but quiet public spaces like parks, a good number of parents who had child care responsibilities were interviewed in their places of residence when the children were either asleep or engaged in activities that did not disrupt the interviews. For the researcher's safety in the latter case, this was done with participants who had been referred by others well known to the researcher with the researcher ensuring that they made the referee aware of the date and time.

5.8 Positioning the researcher – 'Insider' or 'Outsider'

Reflexivity is the process of examining both oneself and the research relationship (Archer, 2007). Given that the researcher is also considered a qualitative research instrument, the personality, demographic background and the following self-reflective questions are important such as; how does the researcher fit into the scene?; will the researcher be accepted?; how will they navigate through and make sense of any preconceived ideas about the topic under research? (Tracy, 2013). These were considered when selecting the research topic and deciding on the participants and data collection methods. According to Fontana and Frey (2005, p.712) 'various factors such as gender, nationality, class and other social differentials 'filter knowledge' therefore in undertaking this research, the researcher was cognizant of their personal history (then a PhD research student; formerly a Human Resources Practitioner; and once having served as a domiciliary care worker while undertaking post graduate studies); gender (female, like a good number of the research participants); social status (this is dependent on how the interviewees perceived the researcher) and ethnicity (Kenyan, Mswahili) as this may inadvertently impact on the interview process and findings similar to some self- searching questions suggested by (Denzin et al., 2003).

For example in recruiting male participants for the study, the researcher used their interpersonal skills, emotional intelligence to make the male participants feel free, to trust me and to open up and tell their stories. The researcher's calm demeanour and active listening also made it easy for the participants to relax and tell their story. Given that most of the participants were female, they tended to treat me as one of them, even where our race or ethnicity was different. The requirement that participants have the ability to speak English ensured that the narrators told their story their own way.

The researcher was required to examine any conceptual baggage, assumptions and preconceptions from their previous experience as an Agency Domiciliary Care Worker, in particular when selecting and deciding on the wording of question (s) to be posed to the participants. Some of the pertinent self-reflexive questions in addition to the ones enumerated above included:

Would the researcher being similar (an immigrant and have worked as an agency employed domiciliary care worker) and being different (that there would be migrants of a different gender, race, ethnicity, culture and socialization, from the researcher and the researcher's student status), aid or impede realization of the research aim?

Coincidentally, the similarities between the researcher and the participants made it easier for this group to open up as evidenced from the interactions during the interview and the rich data collected. The above mentioned reflections informed the preference for story telling/ a narrative interview as opposed to using questionnaire or survey methods. It was noted that none of the research participants had ever been approached before to participate in a study about their work experiences.

5.9 Ethical Issues

Respondents required information such as the identity of the interviewer, the legitimacy of the research, the process by which they were selected and the protection expected by their virtue of participating in this research consistent with Barn (1990). In ensuring conformity with the ethical issues standards required of this research the following were included in the participant information sheet and all documents as approved by the University of East London Ethics Committee and a debriefing on the same was undertaken by the researcher before commencement of the interview process.

- ✓ Clear identification of University of East London as the sponsor for the research, the schools(s) involved the project title, the Principal Investigator and other researchers along with relevant contact details.

- ✓ Details of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved.

- ✓ A statement confirming that the research has received formal approval from University Research and Ethics Committee.

- ✓ A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support.

- ✓ Assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.
- ✓ Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.
- ✓ A statement that the data generated in the course of the research will be retained in accordance with the University's Data Protection Policy.
- ✓ Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact researchethics@uel.ac.uk

5.10 Summary

In this methodology chapter the researcher's thought process while undertaking this research has been enumerated, the subjective nature of qualitative research methods evaluated and explanations why that it is best poised to interrogate the research question. Alternative research methods have been acknowledged including a justification on the reasons why they were not used. The resign design has also been explained.

The never ending and protracted discourses on methodological supremacy have led to Brewerton and Millward (2001, p.12) propounding that 'the point is that debates about what constitutes valuable knowledge are limited in their utility, since it depends largely on what the question is and how it can be best answered or addressed.' Rousseau and Fried (2001) maintain that the varying nature of both work and work settings may have a substantial effect on the underlying research process as well as the results. The researcher concurs with Brewerton and Millward, 2001 and Rousseau, and Fried (2001). Most importantly, the researcher's decision to use IPA to analyze a large number of research participants has been clearly explained. Finally, this chapter set the pace for the subsequent chapters on findings and discussions and conclusions where the relevance and efficacy of the methodology as used will be put to test.

CHAPTER SIX

FINDINGS AND DISCUSSION - INITIAL ANALYSIS OF THE NARRATIVES

6.1 Introduction

This chapter presents findings as well as discussions of the data analyzed from the narrative interviews used in this research. The preceding five chapters systematically presented information that has gradually led to what this chapter will analyze. A total of forty four people, thirty females and fourteen males were interviewed. The research participants were drawn from a cross-section of employers providing domiciliary services within London. Some worked within the care providing agencies, others were employed by organizations /associations described as supported living providers, while some worked under local authority/social services, or for personal budget holders, and payroll agencies. One participant worked for the Care Quality Commission as an inspector, but was included for the research based on their previous experience as a domiciliary carer (discussed earlier in chapter 5 under the pseudo name Kelechi). A migrant herself she has risen through the ranks amidst all the problems and challenges facing her as a migrant, her success story was thought inspirational.

To manage the findings and interpretations of the coding and thematic analysis from the interview data, this chapter is divided into two parts. Part one will offer a recap of the pre- data collection activities and also illustrate in summary how the narratives of the research interviewees began as they tried to contextualize and story the research question based on their individual understanding and interpretation. Part two will reveal and interpret the five themes selected to represent the findings of this exploratory research to address the first two research objectives as the narratives adequately cover this in fusion. This is in line with narrative telling and the inductive approach adopted in the first phase of data analysis. Findings representing the third research objective, concerning psychological contractswill be presented and discussed in chapter 7. The qualitative descriptions of the idiosyncratic meaning given to the employment experiences of the interviewed migrant domiciliary care workers and inferences of the possible forms of ensuing psychological contract will be discussed. The intent of this is to explicate the third research question bearing in mind that the psychological contract is used as a framework for the analysis of the workers experiences.

6.1.1 Part One

Having introduced the section divisions above, part one begins with a retelling of the research objectives and the research question to provide cohesion within this chapter. At the end a description of how the migrant workers narrated their entry into domiciliary care work is offered. This research had three objectives namely:

1. To investigate the lived working experiences of migrant domiciliary care workers in their multi foci employment

2. To examine the tensions within domiciliary care work.

3. To use the work experiences of migrant domiciliary care workers to scrutinize their psychological contract.

Given that the migrant workers are considered a vulnerable population and that the researcher was a conversant associate with this group by virtue of having previously served as a domiciliary carer, being female like a majority of the research participants and above all a migrant too, stories were deemed to be the best method to obtain primary data for use in this research. It took considerable time to construct a question that would solicit the respondent's views about their experiences at work and provide rich data to effectively address the research objectives. Ultimately, the interview question as highlighted below was adopted.

> *'Could you kindly tell me the story of how you found yourself working as a domiciliary care worker in the United Kingdom? Give me specific examples of your day to day working experiences and everything else that you may deem necessary to help me understand your role'.*

The interview question was selected because it was found to give the interviewees the freedom on how to structure their story yet at the same time giving a subtle indication on what needed to be included to answer the research question. Bearing in mind that English is not the first language of most of the participants, neither the interviewer's, the researcher opted for a simple easy to understand statement in the form of a question would be clearly understood by the research participants. The researcher was of the opinion that since the psychological contract construct is still under development, it would be burdensome to explicitly ask the research participants about their psychological contract. Instead, the researcher would listen to the experiences of the participants as narrated through their stories about their work life and then use this to interpret and discuss the possible psychological contracts that this group of workers may

be holding. It is the intention of the researcher to contribute to further knowledge on psychological contract literature.

The researcher had hypothesized that it would be difficult to reach the migrant domiciliary care workers as they are a relatively hidden population. As they were not to be drawn from a specific organization and were not organized there was some apprehension about the success of snowball sampling the method eventually selected for recruiting the research participants'. However, surprisingly, those approached were very enthusiastic and liberally introduced others who met the research participation criteria. Other details about this have been detailed earlier in chapter 5.

6.1.2 A story within the migrant domiciliary workers' story

During the first phase of analysis of the audio recorded interview transcripts, it was noted that the participants of their own volition began their stories with their entry into the United Kingdom, the reasons why they came and how they needed to work and that care work seemed or was the job they could do as fresh immigrants. There were stories about being introduced into care work by earlier established migrants, some from their countries of origin and who were known to them and others meeting unfamiliar migrants in the United Kingdom, making friends with them and later being introduced into care work. At the onset, many of the respondents' perceived care work as a temporary measure as they tried to settle into their new environment. For a good number of them the care job has become one that they have undertaken for several years during their stay in the UK and one they see themselves continuing to be in whether voluntarily (as some expressed loving their job) or involuntarily (being the only job available or . In doing so, that fits their circumstances).

The researcher has used the word 'care work' because most of the research participants began in other divisions of the social care sector and have moved back and forth before settling into their current role (that designated as domiciliary care worker for the purposes of this research). Most of the stories begin with high expectations of a better life in the United Kingdom after arriving from their countries of origin, quickly turning into frustrations at the realization that they had to reinvent their wheel of life to fit into the new country as soon as possible or be faced with the frightening option of repatriation back to the places they had originally migrated from.

A common thread was their initial shock about the job they found themselves having to perform. Migrants from Africa, Asia and the Caribbean described what they termed as cultural shock when they realised that they were performing intimate personal care on clients who were not their relations and that this job was a paid job. They recalled that in their country of origin, care for the elderly or those who have a disability that requires daily living skills assistance was done within the family and that age was factored with regard to who could take care of such persons. Short extracts from the stories of Omoyotosin and Ruwaihim males of Nigerian and Pakistani origin respectively illustrates this:

> *'I was introduced to this job by a friend who was a care worker. He – if I remember very well in plain words he said that –'you are going to look after elderly people so in other words- 'welcome to Europe where you are going to pack shit'.*

> *But the biggest shock for me was you know- in Pakistan it's – personally I never saw a fellow man naked (stresses this in a raised tone) not even to even give a man a wash but culturally and religion wise that was broken down when the need arose. - It's more or less survival.*

Those from countries within the European Union had seen domiciliary care as practiced in their home countries and had an idea about what to expect. However, a major concern was when the participant had a profession or educational attainments that would have secured them a better job in their home country but found themselves having to migrate and be subjected to adaptation of qualifications if they were to work in jobs in the UK similar to their qualifications obtained abroad.

The stories of the initial entry into care work suggest that lack of social capital and awareness about their host country marred their ability to venture into other jobs as exemplified in these excerpts from Saifatou a female migrant from Guinea and Gustavas from Latvia respectively.

> *'I came to this country at the age of 17 with less qualification and there was nothing for me to do. I would say that there are things that you do not know that you can do. So when you meet people in your society, all what they do- they do care job, support work and cleaning or things like that.'*

> *'Some people will do it when they are new in this country but after staying on for some time and learning about other options they may have a different idea about the job and abandon it or feel it is beneath them to engage in such a job anymore.'*

Having overcome the initial challenges of settling into a new country, the participants went on to tell about their experiences as they perform their duties. Analysis of the interviews suggest that they give stories mainly through recalling and restorying (retelling) incidents that mattered to them in the course of their day to day work and presenting them as in the present. Some experiences are very present but like in any story they use past tense in the descriptions. In other cases they used the present tense when they were deeply engaged in the narration and especially if it rekindled emotions. Their working life stories are told by the research participants in no chronological order about the events or experiences and often times they will remember something that needed to have been used to elaborate a topic they had discussed earlier and will go back to re-explain this and contextualize an earlier story. However, when describing their intra-sector movement with the social services sector and into other low-wage sector jobs to supplement their earning or during times when shifts are hard to come by in the domiciliary care work division, they recalled the years and time chronologically. On changes that have happened within the sector, the participants were clear about the years or at least an approximate time range an indication that this was of importance to them as it impacted on the existing care work organization.

6.2 Part Two

The section below presents the themes using verbatim excerpts and also offers some pertinent interpretation for the reader to understand and make sense of the statements. Within the care sector there are words used which a person working outside the sector may not readily comprehend. The researcher's short explanation of the participants vignette may be useful. It is worth noting that in achieving the aims of the research, some excerpts in which the participant is talking about others (within the care giving role) have been included. This is because experience of /at work may occur in a singular or multiple interaction though the narrator gives their own version. The other parties that were included in some narratives are co-workers, the client, the client's family members and the employment agency.

As expected, while undertaking qualitative research a lot of data was collected. The onus was now left to the researcher to make sense of this data. Consequently, in concurrently doing the interviewing and the transcribing and thematic analysis five (5) themes were identified which are

further exhibited and interpreted through the use of vignettes and excerpts interchangeably. This approach fits well within interpretivist and hermeneutic phenomenological data analysis methods. It is here that the research participants are accorded an opportunity to have their voices heard. One of the challenges faced by a researcher using narratives and interpretive phenomenological methods is that of deciding whether to paraphrase the vignettes or to display them in their origin verbatim. After careful consideration of the quality issues in qualitative research, the researcher chose to use selected verbatim excerpts of the stories that representatively discussed the identified themes. However some other participants' views are incorporated in the discussions section.

There were a good number of themes that were identified from the analysis of the verbatim data. However given the word count limitation, in keeping with the research objectives and that this data would also be scrutinized using psychological contract literature five themes were thought to be most relevant for inclusion in the findings of this research. They are: challenges with communication; prejudice; time constraints; safety concerns and disquiet about the training provided. These themes had sub clusters that exemplify them based on the selected research participants' stories. These have been integrated verbatim within the core themes and it is from these that discussions emanate.

6.2.1 Challenges with Communication

The difficulties that were narrated under communication were chiefly around language; verbal (speaking) and non-verbal (sign, gestures and facial expressions); writing, accents, comprehension and parlance. In performing domiciliary and other forms of care work language is a key issue. Vignettes by Darelin, Nasra, Abhik, Lonut and Jenson were used to highlight this. The participants talked about their communication with their client, their client families, other social care sector partners and the communication with their co-workers.

> *Some people don't understand the language and you give them a care plan and because they can't read the English properly, they say it's not necessary. But I always insist it is necessary. It is difficult for a grownup to admit they can't read.* ***Darelin, Male, Barbados***

Darelin is discussing the importance of ability to read and to write in the job of a domiciliary carer. Part of the job requirements are that one will read the care plan, implement the tasks as per the care plan, communicate with the service user (assuming they have mental capacity) and make

recording notes. If a Carer is unable to do so then it not only affects the quality of care but also places undue pressure on their co-workers and the client. Though most of the tasks undertaken in care work are repetitive and appear easily learnt experientially there are some tasks that call for a certain level of verbal and written skills as a minimum. Most migrants are non-native English speakers; some even have had to attend English language beginner classes. If speaking is a problem, then writing is expecting too much from such people therefore during a shift they would prefer to do the manual aspects of care which they consider a common sense approach that can be learnt experientially.

> *There is a problem of people speaking or using their own language in front of the client and their behaviour… how do you say it- culture they bring it at work which should not be brought at work. I have witnessed it. The first time I went to Client X his mother commented, 'oh finally – someone who speaks English' because they were sending him Eastern European carers who spoke their mother tongue during the call. The client was getting irritated and became uncooperative because he didn't understand them. **Nasra, Female, Kenya***

Nasra is referring to circumstances where carers converse in their native tongue when attending to a client. This can alienate the client as well as another co-worker who may not be of a similar tongue. It portrays a lack of intra-cultural awareness and can affect the relationships at work.

> *For service users there is a language barrier which is a big factor. Even though I can speak English very well- I have an accent and sometimes when I go to these elderly peoples' homes they struggle with my accent. Sometimes they are asking you- Are you speaking English or what- Say something I will understand. If you are not strong as a person you will be put off. Sometimes you have to be repeating yourself again and again so that they will understand you. Among your colleagues you also find some that would set you up- I have had that a lot. - that will probably set you up with a client say- because you are from Bangladesh or because of your nationality they would say- oh this person doesn't speak English- they will have a chat with the service user and the service user becomes unnecessarily difficult towards you. Some mimic your words you say, insult you and isolate you from the team. **Abhik, Male, Bangladesh.***

Abhik is of Bangladeshi origin. He acknowledges that despite having a good understanding of the English language, his regional accent presents some difficulties when he is communicating with a native English speaking client. He further talks about co-workers who would also want to capitalize on his being different to encourage service users to give him a hard time as he is doing his job. According to Abhik, language, the accent and country of origin are also used as identifiers of discrimination and to perpetuate exclusion.

*I have lived in Austria before coming to the UK though I am originally from Romania. I speak, German and so tend to first think in German before responding in English. If I do not know the English equivalent I just utter in German or Eastern Romanise and this annoys my client's. I am still trying to improve my language skills but I have no time for formal learning so have to make do with the limited chances I have when talking to clients or other colleagues. Because I am white both my colleagues and clients automatically expect me to speak good English and get surprised and sometimes annoyed by my inability to speak fluently. (**Lonut, Male, Romania**)*

From Lonut's experience, his white skin colour is taken to mean that he should have a good command of the English language, which he does not. He is treated differently on realization that his English is 'imperfect'. He however emphasizes the fact that he is multi lingual- can speak Romanian, German and his not so perfect English. The challenges migrants from non-English speaking countries face as they try to settle and to obtain paid employment in the host country are highlighted in Lonut's story. Enrolling into a language school would be the easiest and preferred way to quickly learn the language, but a migrant is mostly concerned with eking out a living before he can have spare money and time to enrol for such courses. Within domiciliary care the employers do not have the responsibility for training staff on English language skills. It is taken for granted that those applying and obtaining jobs should have a fair level of English language literacy and speaking and if they need to improve this it is their responsibility to put into place measures to ensure this.

I have a lot of anger when the agency tells me that a client is requesting for 2 Urdu speaking carers. I often wonder what this is all about. Is it an attempt to deny other ethnic carers work? I have never in my many years of working had any client phone up to say they need people who speak Ghanaian or Nigerian or other African language. The Bengali clients will ask for Bengali speaking carers within Tower Hamlets. What chance have you got if you are from another nationality- You haven't got much chance? If the clients are looking for Bengali speakers and you are dominated by Bengali's or say Asians, and then because the only language you speak is English you are disadvantaged. **Jenson, Male, Antigua.**

Jenson works in Tower hamlets, an area dominated by the Bengali community both as carers and as clients. He is of Caribbean descent and the only language he speaks is English. Since he cares for the elderly it can be expected that a good number of them may prefer to have carers they can talk to in their native language, maybe even of a similar cultural and religious background. Jenson argues that this is somewhat discriminatory as it places unfair competition for the jobs available within the borough. But yet, it is better for a client to specify their preference upfront

than for them to refuse to be cared for by a certain carer when the carer has already been assigned to them. It is important to also point out that old and elderly people do not like change and uncertainty. It might be that the clients of Bangladesh descent feel safer and more at ease with carers with whom they share a language, some of these clients though they may have already obtained British citizenship and may also have the ability to converse in English.

In summary the stories of the participants expressed how important communication was as they undertook their work. Even where the client has impaired hearing, sight or speech, there are adaptations that have been made to ensure communication. Some participants expressed having been taught Makaton, braille and even the British sign language to enable them to meet the communication demands of their clients. Effective communication is part of team working. It was storied that some of the clients have no one apart from the carers to converse with, hence look forward to the visits by the carers so that they can at least talk to someone. Where time allows or the nature of the care work is that it is possible to chat while performing the work, carers relate with their clients. When time constraints do not allow, carers just get on with the job in a mechanical way to complete it within the contracted time.

Written communication is very important in domiciliary care because of handover notes records which are used for continuity of care and may even be adduced as evidence in administrative and criminal investigations. It provides a paper trail, confirms authenticity of actions taken in compliance with the care plan, can be used to monitor for example a client's behavioural changes, the body map locates the actual bruises or tears on the client's body and this can be useful for safeguarding related issues.

Medication administration, creams, turning chart records and pad changes information as well as fluid and food intake charts are some of the useful written communication that can help in evaluating and maintaining quality social care provision for the vulnerable clients. Accurately using and literally mapping any noted scars, bruises, scratches, swellings or pigmentation changes on the body map (A diagram with an illustration of the human body parts used bythe carer to record any visible changes/injuries on the client's body) can assist in matters about changes in the client's health and also for explaining any tissue tears to safeguard against claims

of a carer having inflicted injuries on a client even when some clients or their family members are responsible for this. It can also inform an incoming carer about issues they need to pay attention to.Communication in all its forms has an effect on whatever type of psychological contract the employee holds.

6.2.2 Prejudice

In interpreting the work experiences of migrants from both the literature reviewed and from the data analysis findings concerns like discrimination, stereotyping, racism, exclusion and other overt and covert mistreatment were encountered. Using an interpretivist and hermeneutical phenomenology approach, the stories had to be understood for what they were. The perceptions of the narrators appeared real in their descriptions of what they thought the action performed against them was. While it may not neatly fit in any of the categories as suggested above some perceived maltreatment did nevertheless happen irrespective of the wording used to describe it as categories intersect. Interestingly, findings were that clients were opinionated against the migrant carers but surprisingly some of the participants also practiced prejudice against fellow migrant co-workers even though they had been (or were likely to) have others insinuate differentiation statements against them and while doing so some seemed to rationalize their action while others felt vindicated. The narrators chose to story their experiences from their encounters with clients and with co-workers. In interpreting and labelling this theme, the researcher could identify with and reasonably assign them to where they fitted, drawing from the literature reviewed and by virtue of being a Conversant associate with these migrant domiciliary carers.

The following vignettes by Okoronkwo and Darelin show male carers experiences of feeling underrated by potential clients due to their gender. This can be construed to be a form of bias. Though only these two have been included in the findings, most of the male research participants expressed similar opinions.

> *Some female clients are very apprehensive to have me care for them due to the fact that I am Black and male even when they are Black themselves. Even White ones too. They find this repulsive and ask if there really is no other female to help. After some of the female clients seeing I really work well - respect their privacy and personality - they would be very appreciative that it was me who cared for them. Others even refuse to open their doors for me denying me access to their premises. In this case I would lose job hours and this is unpaid.* **Okoronkwo, Male, Nigeria.**

Okoronkwo is commenting on his relationship with his clients. There are intersections in the challenges he faces. Firstly, he is a male in a female dominated occupation where most of the clients are elderly female and would prefer female carers even in a double up. Though he is Black, one cannot attribute his predicaments to racism because he says the treatment is from both White and Black clients. He also points out that where he has been allowed to care for the clients some of them end up being really grateful about how he performs his care role towards them. In such a case, it may have been a case of initial indifference from the client by seeing themselves different from Okoronkwo especially through gender and later realizing that he can perform the job as similar to the standards of a female carer. Refusal to open their doors when they realize he is a man is either due to the apprehension of having a male perhaps perform personal care work on the female clients and therefore ill at ease therefore not necessarily discriminatory or it could also be racial or even a combination of both. He is however entitled to his opinion hence the individuality of the psychological contract about expectations as are those who view him differently based on whatever criteria they are applying then.

> *Maybe it is natural to say that women are more caring but I don't think it is something that cuts across a particular gender. You know some people can even spell it out clearly – for example a man can say, I don't want any man to come and look after me in case they are gay, but being gay is not written on anyone's face. So most times our male clients prefer to have women (laughs cynically) sometimes you know , you have some male clients and when they have an option of having a cover, let's say if for example I am on an emergency off or call in sick, these men when requesting for cover will specifically call particular women to care for them. So it tells you that it more or less something natural - maybe males will want a woman to look after them.* **Darelin, Male, Barbados**

The next stories from Astrid, Dominykas and Musin show how both clients and co-workers remarks and attitudes can and do affect the work experiences of migrant domiciliary carers. Ignorance of peoples' culture, history and even world geography may be explanations as to why people use the known 'stereotyped traits and myths' about others to form an opinion on a group. Some of the clients may never have even met people from some of the countries that the migrant domiciliary carers originate from.

Sometimes even in making innocent conversation they may offend the carer. Other times it may be deliberate and vindictive. On the other hand carers are also of different races and nationalities and they too may never have met nationals from the countries their co-workers hail from. They can also have their fears and biases.

155

*I have had very bad experiences with clients and co-workers who keep asking me which part of China, Korea or Japan I originate from. Some even gesticulate to mime my shallow set eyes and facial profile. Another client even asked me if I can see them clearly as they cannot seem to locate my eyes. I am Filipina and proudly so. I often look for a stereotype about the race of the offending person and unleash it on them to get even. **Astrid, Female, Philippines**.*

Astrid is unhappy about being defined from her physical features and even then wrongly identified as from other Asiatic ethnic groups that may bear similar looks. She has however devised the method of acquainting herself with ethnic stereotypes about her disparagers to hit back with. While she may have little control over how people judge her from her looks she has identified a coping mechanism.

*When I first came into this country, the clients would think that I am Polish or Romanian. They would sarcastically ask me if I had plumbing skills, if I came from the village in Romania where they train pickpockets. Some would eye me suspiciously thinking I would be a bin raider. From the clients I could explain it on their ignorance but when my co-workers made stale jokes about Eastern Europeans it hurt very deeply. When I explained that I am from Lithuania they said 'you eastern Europeans are the same! Due to these experiences I prefer to work with and among people of my country. **Dominykas, Male, Lithuania**.*

People react differently to the negative experiences at work. While Astrid above is proactive in dealing with her situation, Dominykas has given up. He has accepted that this stereotyping is there to stay and his reaction to it is by consciously finding solace in working with people from his country. However, if he works in a double-up, there are not very many Lithuanians to work alongside and this may impact on his earnings as a result of fewer shifts.

When I am working with a client or co-worker for the first time, I get upset at the way they assume to know where I come from based on what they think I look like. Some ask me about Somalia, others about when I came to the UK from Comoros or Mauritius.

*When I look perplexed as I have never been to these places, they then ask me where I am from. When I say Egypt, they say,-we have never seen an Egyptian of your complexion and hair colour. Aren't all Egyptian White/Arab looking? For me my skin colour or features should not be an issue. My ability to perform my care tasks should. That I am Muslim has also sometimes been used to discriminate against me. They tell me to make sure I do not detonate a bomb in their house. They tell me that I am lucky not to be languishing from the political turmoil they see about Egypt on the news. **Musin, Male, Egypt**.*

Musin is from Egypt. His mother is an Arab (white) Egyptian while his father is Sudanese with Nubian features. Musin's race or ethnicity is hard to define for both his co-workers and his clients. When they are told that their carer is Egyptian, they expect a 'white' but Muslim or Arab looking person. So, Musin stated that when they see that he has bi-racial features they are at a loss about his ethnicity and begin to apply stereotypes to define his ethnicity/race. In Egypt, where Musin hails from, Muslims are a majority. There are also a good number of his country folk who have multi-racial backgrounds. He has now found himself in London not only as a minority (in the BAME group) but also of a religious group whose followers are sometimes considered extremist.

 In the segment below, the researcher has included the stories of Saifatou, Zanda, Kemi and Nasra which suggest they have encountered episodes of racism based on skin colour and physical attributes from their clients. Saifatou, Kemi and Nasra are Black African and seem resigned to the fact that racism is part and parcel of their work situation. Zanda is Caribbean and does not consider herself African. She however is of very dark complexion and would pass for an inhabitant from Africa to some people. The four carers have experienced a form of racism but their individual reactions differ. It is worth mentioning that some of the stories are told by the narrators using derogatory and strong language and have been presented from the participants actual recorded accounts.

> *As a migrant in this country the racism…., I didn't know what racism was. It's only when I started working and living with neighbours , then I saw how people are horrible calling me 'Black Mamba' because of my colour, refusing to be assisted with care. I had never experienced that because when we see White people in our country, we embrace them; we love them and see them as our own despite the colour difference. But when you move to the western world, then you see the nasty side of this people. The way they treat you because of your colour, the way they talk to you, they see you as a criminal, a suspicious character, some even tell you that you have come to bring sickness to this country.* **Saifatou, female, Guinea.**

> *I had a client who called me 'Fucking African' but I didn't take it personally because I knew she was in pain, so maybe that was a way of her to express her feelings. But then again, I am not African, I am Caribbean and I told her so.* **Zanda, Female, St Lucia**.

The retort from Zanda to the client who had identified her as African is a case of her asserting and communicating what she considers her identity as opposed to the identification by the client. She seems to attribute the 'Fucking African' affront to the client's physical or mental impairment

and excuses it. It is her being referred to as African that is a big issue to require a clarification from her.

> *Look at you fat black cow, look at your black face and short kinky hair, big butted bitch, get out of my house! It hurt me but that's part of being a migrant. **Kemi, Female, Nigeria**.*

> *Sometimes you go there – I have been called monkey- I have been told- what are you doing here- go back to your country but again – even though they can be painful comments you need to get past it and do your job. You will report it obviously- you are encouraged to report but what can be done about it apart from speaking to the perpetrator. There is little that can be done about it. I think it is one of the qualities – the skills a good care worker needs to have- you need to be able to deal with those difficult situations. **Nasra, Female, Kenya.***

The following excerpts from Shema, Seykeda and Omoyotosin bring out how migrant carers can also profile their co-workers. Since this research was about the work experiences of the participants, some of them found their relationships with co-workers so important that it warranted a storying.

> *I have mostly worked with West Africans and Caribbean's. What I say is that both these groups are very loud. From my culture- the way I am brought up- or the way my culture is- we are not loud, we don't talk loudly- even when you are talking you have to be very very polite- that's my culture. I first used to think they were quarrelling or rude. Sometimes it frightens the client. And I think that's their culture to be very loud spoken. **Shema, Female, Bangladesh.***

Shema is of Asian descent and a Muslim. She is soft spoken and is describing a situation where her co-workers speak loudly. She even singles out persons from two geographical regions. The speaking loudly does not augur well with Shema. This is not racial though Shema is of a different race from those of the groups she is describing. It is a case of cultural and ethnic stereotyping.

Shema is not the only one who felt that some certain group of domiciliary care workers was rough in the way they handled clients, rude and boisterous. Examples cited included those from Nigeria and Jamaica while many opined that East Africans were polite, gentle and amiable as were Filipinos.

Eastern Europeans have descended onto care jobs like fleas. They are a people who work and over work, their work ethics is about competing for and grabbing all available shifts. They like to move to the top, some have come trained as nurses and their first port of call is within the social service sector whether in domiciliary or residential care, they are ambitious seeking to quickly move into higher echelons in the professional ladder. I do not like these mannerisms and they rub earlier migrants from other communities like me the wrong way. They use their white skin colour to bully other races and to endear themselves to clients and managers for more shifts. **Seykeda, Female, St. Lucia.**

Sekyeda's opinion about Eastern Europeans shows a critical and disrespectful attitude. She even comments on those who have had prior training as nurses and are now undertaking domiciliary care work in a disparaging manner. Sekyeda is being xenophobic, though her sentiments also have economic motives about fear of possible loss of job shifts meaning less money. It is more like she has stereotyped the Eastern Europeans. Her mention of the white skin colour of the Eastern Europeans should not be highlighted as being racist it is best understood under 'Whiteness' where there are assumptions that the white skin colour may lead to white people being treated more favourably by other white people. This will be elaborated further in the discussions chapter.

My relation with Eastern Europeans and Indians and Filipino's is frosty. They think because they have lighter skin they are better than me and other non-white carers. Some clients also think the same and treat these groups more favourably. This really pisses me off. **Omoyotosin, Male Nigeria.**

Here Omoyotosin though sharing some of Seykeda's sentiments can be seen to be expressing racist thoughts in his story. He has included Eastern Europeans (who are White in colour), Filipinos who can be considered Brown, as are Indians. He specifically mentions that they think they are better than he and other non-white carers. This is overt racism. His remark '***This really pisses me off***' is pejorative and deprecating. This attitude is not conducive for harmonious working relationships. It is based on a reactive negative feeling of being discriminated against.

The following description from Balkissa has been included in these findings section because it recapitulates the possible reasons for the deep opinions on other migrant populations by Seykeda and Okoronkwo above. Balkissa introduces aspects of the concerted efforts by the government to entice more 'white' people into the care industry even though the preference would be more 'indigenous British' to reduce the over reliance on migrant workers. The white clientele make do

with the 'new white' carers for racial preference reasons. This will be elaborated further under discussions.

> *Before the flow of the EU, the Black population migrants dominated the care sector coz it was a sector where white people didn't want to go into. So the Black people –that's an easy job - so we flooded the sector. I am not sure they liked it both the service user and the senior management. Now we have the EU people- they are white. It is easier for them to in order to get white people into the care sector, they are giving them the opportunity even when they are not experienced and sometimes, I don't know if they find them easier to work with because – I don't know - I understand they are more cooperative. Some of us Black people - we can be challenging. I think it's more of a colour thing.* **Balkissa Female, Cameroon**.

Borrowing from Jenson's statement below, it can be inferred that the migrant domiciliary care workers have accepted that being seen as different and also seeing themselves as different is a constituent part of their lived working experience they have to live with. The challenge is how to mitigate it and forge on to perform the work they need to do.

> *People are like boiling a pot, if you are boiling a pot and you are boiling dumplings you don't put egg in it because the egg will finish before the dumpling. So straightaway you've got to put all eggs in the same put and dumplings in the same pot.* **Jenson, Male, Antigua.**

In summation, the issues categorised under the theme of experiencing prejudice and its variant forms of these were found to be part of a domiciliary migrant's lived experiences. Though, to the reader some of the stories may seem hilarious, to some obnoxious, these are stories of real experiences that have happened or are happening to the narrators. There were however stories of clients who were respectful, co-workers who treated the research participants with decency irrespective of their race or other distinctive features. Many of the interviewees told of stories that show they are treated differently, feel different and in their opinion this will continue to be so.

6.2.3 Time constraints

Time constrains (limited and not enough) emerged as a very important aspect that affected the migrant domiciliary carer day to day operations and experiences at work. It was so important that the researcher deemed it necessary to capture these by appropriating other attendant sub themes to understand time as it impacted on the quality of services offered, relationships with clients and co-workers. There were many codes identified that alluded to issues about time. Upon close and repeated re-reading, it was found that time is a central theme around which most of the carers experiences are enacted. To enhance understanding of time constraints it has been split into two categories namely; firstly those that are service- provision related - time and, secondly those that are carer related inhibitions - time (those emanating from the nature of the job and impacting on the carer themselves). The researcher selected the most compelling excerpts to give voice to this theme but other submissions are collectively interpreted and included in discussions within this chapter.

Service provision-related -time

Below is an extract from Livia's story to show how fragmented time impacts on the quality of care. She is narrating about how some clients who have been assessed as qualifying for calls where they require to be assisted with feeding are short-changed by being offered unrealistic units of visit time. Livia feels for the client and expresses the wish that this kind of time units be investigated by the Care Quality Commission as they are a form of 'abuse'.

> *CQC should check on domiciliary as well but I think they never do it. They should do it because people are not getting enough hours to be looked after is like abusing them because like if you are given 15 or 20 minutes for lunch time- I have worked in such shifts- 15 minutes you cannot feed someone who needs feeding. Even me I feed myself I cannot eat in 15 minutes. So CQC should also check on domiciliary care not only on residential and nursing. Even though I am sympathetic with the client, I have a next call which is straight after this and is therefore unable to extend further to allow her to complete her meal. I feed her until the lapse of my time, any leftover food is put in the fridge until I come next, warm it and give it to her. Sometimes the client may ask me to bin the food and clean the plate. I always wonder has the client had enough food. This is unfortunate.* **Livia, Female, Romania.**

The following excerpts from Alayna, Jenson and Kelechi deal with the transport aspect of travel to the clients house from their place of residence, then travel in between clients houses during the course of the day to undertake the shifts they have been assigned. Since the nature of domiciliary

care is that the hours allocated are indicative of the actual face to face contact with the client whilst offering the care service, then, the hours can be fragmented in such a way that the carer has a substantial amount of travelling to do, yet the shifts are supposed to start at the allocated time. Unpredictable changes in the transport system such as cancellation of a train, delay in a bus or sometimes a carer being late and missing their transport or in other cases, for example; where one has difficulty in identifying the client's physical address may lead to frustrations on the part of the carer, annoyance to the client who is paying for services and expecting services to be delivered on time. When employers give shifts in geographical areas that may be seemingly close but logistically apart undue pressure is exerted on the carer to ensure they attend to all the clients allocated to them.

> *Sometimes the agency does not take into consideration that there is travel time involved so they give me shifts, which by the time I finish require me to take a bus to the next place which is far hence it is very unsettling as I may be late. If you have been given shifts that are very close in time and you get late to one it will impact on the next one.* **Alayna, Female, Cote d'Ivoire.**

> *It's like you will be moving helter-skelter like a headless chicken the whole day in between client houses back and forth and because travel time is not factored in and paid for, you could find that you have been busy for about 10 hours but the take home pay is for only the time you clocked in and out at the clients. This is very demoralizing.* **Jenson, Male Antigua.**

The choice of words as used by Jenson …**'moving helter-skelter like a headless chicken the whole day in between client houses back and forth'** summarize his anger and frustration at both the inconveniences of domiciliary care and the transport hardship as well as the impact this has on his take home pay.

Despite the impracticability of no provision for travel time in between shifts at times, the carer in most cases resort to what Kelechi very aptly describes below:

> *In the past when I worked as a domiciliary care worker we had allocated contracts 37 hours. And we had time from one call to the other highlighting travel time and this was paid for. Now it is not paid for. These are the pressures they place on the care workers and that is why they can't provide good care. Because you are not paid travel time, if they have one hour to care, they slash the travel time for there and hurriedly do their job in less time to try and leave earlier for the next call where there is no time clocking system. Where timing is manual they write they have been there the full time but leave earlier.* **Kelechi, Female CQC, Nigeria.**

In the circumstances where some employers send the domiciliary carers to rural areas or places that are remote and not easily reachable through public transport, such carers were allowed to use their personal vehicles. There are some advertised domiciliary care jobs that require that those interested must be car owners. Time is hereby being discussed from a different angle. It is about compensation for use of personal property to attend to what is a straight forward organizational assignment that is of benefit to the organization but for which no official transport is availed. Those who commented on this felt that the mileage paid was too low and not commensurate with the wear and tear of the vehicle, the problems the carer had to contend with about parking space when while in the client's house and that the rates were fixed and were not reviewed to reflect periodic inflation rate. It may be a case of the carer bearing the brunt of the low profit margins that the independent sector care providers make, thereby making them unable to pay sufficient rates to recompense the carers for use of their private vehicles. Albeit to say, some respondents stated that some of these work shifts may be for between 15 and 45 minutes therefore not viable and placing a dent in their pockets as they are already in a low paid employment sector. Yet, if these are the only shifts on offer they just get on with them hoping for better times and rates with the same or a different employer but in the same sector.

The following excerpt from Iker has been selected to sum up the interrelation between travel time, transport and the quality of care as well as the ethical dilemmas domiciliary carers find themselves in.

> *I have a very bad experience with one lady, eeish… you need to look at what the people do – you see. It was time for a client to be put into bed. A very frail man. So this lady because she wanted to finish in time to move on to her next client, the way she handled the guy- I can't even describe it to you properly it was terrible (almost whispers) I said to her, I can't work with you. The way she lifted up the client, put him on the bed and changed him, I said no nommmm…I can't work because I will be in trouble. And this is not the way I am working. Even if it takes longer, you know sometimes some of them can punch you, you know things like that. But you need to know whom you are working for. I said to her if they had a CCTV here - we would be out of the door.* **Iker, Male, Spain.**

Iker illustrates an example of a client being at the mercy of a carer who is working to beat the clock and provide the client with all the service documented in the care plan within the allocated time. Iker's lady co-worker behaviour may be attributed to trying to finish up task within the time constraints. Whereas Iker on the other hand seems to wish to operate from an altruistic angle as his narration **'And this is not the way I am working. Even if it takes longer, you**

know sometimes some of them can punch you, you know things like that ...but you need to know whom you are working for'. However he is also afraid of being in trouble as he states, **'I can't work because I will be in trouble. I said to her if they had a CCTV here - we would out of the door'.** Being out of the door implies not only job loss but even a criminal conviction for neglect if the client complains of the treatment. This may lead to an investigation of abuse, a conviction leading to a criminal record being registered against both Iker and his co-worker. So much is at stake here because it is a requirement that a person working in social care services have a clean record. Such a conviction can jeopardise Iker's chances of future employment and may even land him in jail and/or even being deported.

Both Iker and the client are in a vulnerable position. The offending co-worker may seem to be calling the shots at this particular time but she is reacting to the pressures imposed on her by the fragmented time arrangements. The mention of a closed circuit television camera for surveillance purposes shows that carers are aware of the monitoring and controls that are put into place in the industry for safeguard purposes. If this device was in place then maybe Iker's co-worker may not have behaved in this manner. But then again, is it not expected that carers do their jobs without having to be micro-managed to ensure acceptable performance? What about ethics and professionalism? Is the labour process aspect of domiciliary care alienating the workers from their work? This may appear so. The difference between the reaction of Iker and his lady co-worker demonstrates how each individual can react in a similar situation. They both are in a 'double up' for similar time frames yet their responses on how to undertake the assignment are dissimilar, hence the individuality of the interpretation of their job obligations.

Stories were also told about how sometimes carer's in their hurry to provide care within the allocated time ended up scratching, tearing the skin of their fragile clients as they were dressing or undressing them, some even attempted to hoist clients on their own if the 'double-up' was late and sometimes this led to accidents, which unless serious and visible the carers did not record in the incident book for fear of arousing investigations on safe guarding issues.

Carer related - time

Next are the stories about time constraints that are personal to the carer but impact on their job and their wellbeing socially and economically. They have a direct relation to the nature of the job they are engaged in.

Employer instigated Zero hour contracts

The use of zero hour contracts by employers within the domiciliary care sector was mentioned in the narratives of almost all of the participants. As contingent employees, it might be assumed that they prefer flexible contracts that will allow them to choose their preferred working times and patterns (Rubery et al, 2015). Bearing in mind that most of the carers are women it would seem that they might prefer to be on zero hour contracts (see Wills, 2003). However narratives of both men and women suggest that a good number of them are on zero hour contracts because that is what the labour market offers and dictates. Some of the participants do not have any formal contracts and so infer that they are on zero hours contracts due to the fact that they are not guaranteed a minimum or maximum daily, weekly or other hours of contracted work.

> *Let me tell you something that is very interesting - I was not offered a contract. My job was purely zero contract hours. So, if I don't work - I don't get paid. My holidays were tricky because you don't get paid for holiday. So – and there is a common saying that we had amongst ourselves that 'This job is just a slave job' because when you come to think of it- how much was my salary then - £6.50 per hour. £6.50 per hour is not even the London Living Wage. £6.50 per hour is more or less hand to mouth. So by the time you do your personal expenses- pay your transport - you have little or nothing left. So, it's a challenge on its own'.* **Omoyotosin, Male, Nigeria.**

> *Sometimes it can be very quiet, you can go for a week without a shift and this will not be able to help me pay my bills. I have to revert to looking for work in residential care and even do cleaning jobs during such bad times. Also it is very tricky to arrange child care when you are on a zero hour contract. Sometimes they are offering you a shift and you had not organised for a child minder, you have to pay higher to get an impromptu child minder and anyway how much am I making per hour? It will all go to the child minder yet if I decline the shift I may not be offered another to teach me a lesson. It is hard. You also worry about the safety of your child with an unlicensed child minder.* **Sophia, Female, Spain.**

It is ironical that despite there being a general impression that care work is freely available this is not always the case. The changes in the social care sector have resulted in fewer jobs though the number of aged and vulnerable adults continues to increase. Sophia is forced to ply her services in a cross section of low wage jobs to make ends meet when shifts are not forthcoming within

her primary role as a domiciliary carer. This is not for better pay but for subsistence reasons. A carer is expected to provide care for the client for whom they are entrusted. However, if the carer is experiencing problems about arranging care for their child, then even if they eventually work out something they will be ill at ease as they are performing their paid job since another important aspect of their life that of providing nurturing care for their offspring, is suffering. To some extent the flexibility that is deemed to be offered under zero hour contracts is questionable from the findings in this research (see Corby and Stanworth, 2009).

The following excerpts from the stories of Musin, Cheyenne and Dominykus typify the feelings of a majority of the research participants on zero hour contracts.

> *At the moment I am on zero hour contracts because I have no choice. That's another thing- choice - you don't have much - much or none. In this case none. I feel like I am hanging in the air… no assurance of if I will work the next day, sometimes even I can be without shifts for a whole week. Where am I supposed to get money for my sustenance? Yet there are plenty jobs advertised in the media.* **Musin, Male, Egypt.**

> *I don't agree with a zero hour contract. If you want to give me a 6 moths or other fixed term contract then do exactly that, but for God's sake do not give me a zero hour contract.* **Cheyenne, Female, Belize.**

> *Zero hours are used by people who use the system because the system - the government has made it legal so you can use this kind of stuff. Many people have suffered over the years; you work, no holidays, no benefits, if you are sick, you wait until you get better to resume work to start being paid for the hours you will now work.* **Dominykas, Male, Lithuania.**

In recap, the stories of the migrant domiciliary workers participating in this research were that working in zero hour contracts was not as a result of their conscious choice which confirms similar case study findings by Peck and Theodore (1988). A majority of those interviewed opined that these contracts have been forced on them by the employing organizations and by the constraints in their visa and immigration status. Even those who applaud the flexibility of zero hour contracts feel that it is better to have a set number of hours that are guaranteed and to then fix shifts around ensuring they give their employer the agreed contracted times. Finally, the descriptions by Dominkyas, Musin, Omoyotosin and Sophia show a case of satisficing. The role of unions is important to weed out   these malpractices.

Leave

Leave was one of the sub themes that were quite emotive amongst the participants. The few who were working in organizations with robust human resources practices and especially those under supported and assisted living employments where there is inspection by the Care Quality Commission reported being paid for any leave they had earned. However, many of the participants were unsure on what were their legal entitlements if any? And in particular, with issues around sick pay due to their contingent employment status. Leave (paid and unpaid) appears to have a correlation with zero hour contracts based on the stories of most of the narrators.

> *I work for an agency and they send me to assisted living settings. I work on a zero hours contract for 6 days a week but do not qualify for paid leave, neither do I have time to rest or take a holiday as I desperately need every coin I make as a single mother with three kids.* **Lizabeta, Female, Latvia.**

In the case of Lizabeta, she is working in supported living but through an agency. This kind of employment setup undergoes inspection by the Care Quality Commission. For this reason, the agency ensures that the training records of Lizabeta are up to date as the supported living contractor is required to have in their files the training records of any staff who are engaged to offer mental health support to clients irrespective of whether they are employed by the main contractor or sub-contracted through an agency. She therefore benefits from agency sponsored training.

The flip side of this though is that her leave matters are left to be between her and her employment agency and so this goes undetected even when an inspection is conducted as she is not a core worker but is treated as self-employed. She therefore does not get similar benefits to those enjoyed by permanent members of staff in the same employment though she does a similar job when she is on shift. This also is true for her hourly pay which is £7.20 per hour even when she is doing support work while other support workers earn £9.50 per hour and other benefits. It is quite upsetting for her and others in similar situations. This confirms that there is no growth, as there is no clear career path within domiciliary care. This is because those doing support work that often requires administration of medication end up earning the same salary as if they were care assistants. Even in residential services, one can grow to a shift coordinator and earn a higher wage. An important aspect about Lizabeta's contract is that it has an exclusivity clause that

167

disallows her from taking on employment with clients that she has been introduced to by the sending agency. With regards to this, she cannot be poached or headhunted by the supported living organization, even though she would get better pay if this were to materialize.

Some employers who use explicit and implied zero hour contracts have devised a mechanism through which they have perfected the act of ensuring non-accrual of leave even for 'employees' whose period of continuous service would ordinarily qualify for paid leave. They break the 'continuous service' by ensuring a weekly break where the employee is not offered a shift so that the cycle begins anew thereby making it very problematic to qualify for and to even have cumulative leave aggregated. The stories of Jamila, Salieu and Omoyotosin allude to this.

> *Throughout my 2 years employment in domiciliary care I have never been given any leave, paid or unpaid. Any period I have been away from duty was either because I was not allocated a shift as I am on a zero hour contract. Any absences during allocated hours are treated as offs with no pay.* **Jamila, Female, Pakistan.**

> *In this 6 years of my employment I have never had any paid leave as I am working for my agency on a zero hour contract. There is no clause about leave in my contract.* **Salieu, Female, Sierra Leone.**

> *In a good number of my employments with the agency I am not paid any leave allowance. They say I am not entitled to leave as I am considered a part time worker. I am not sure if this is legally right, but for me, I just need to have my pay for the hours I have worked, so I do not concern myself with leave pay issues.* **Omoyotosin, Male*, Nigeria.***

 Some employers have taken advantage of the loose interpretation of the zero hour contract and that most employees do not understand them to take advantage of the workers, Simply put workers on zero hour contracts are entitled to statutory annual leave and the national minimum wage but it is difficult for the employees on such contracts to get what they are entitled to. There is evidence from literature that when the travel costs are not factored into the pay the employees end up earning less than the basic minimum wage. However, hope is not all lost. There have been improvements in some employments where leave and other statutory entitlements are now being paid to employees as the concluding stories by Jenson and Priyanti indicate.

> *Now I have 2 weeks paid leave in my current contract. It's because of the law, that's made them have to do this. Otherwise I would still not be paid. Jenson, Male Antigua*

> *There have been instances where I have been paid money in lieu of leave especially during the period my visa is about to expire and I need to be away from employment until a new visa is forthcoming.* **Priyanti, Female, Bangladesh.**

In summary where there is lack of clarity on the employment status of a worker there is a likelihood that they will miss out either partly or in whole on the statutory leave that is legally provided for under the law. Such include maternity and paternity leave, sick leave, statutory sickpay, bank holiday pay, holiday entitlements and a host of other employee rights while on leave.

Poor Work-life balance

This is closely associated with leave, rest and recuperation. The nature of employment that the domiciliary care worker is engaged in influences their work-life balance. The stories of the women and men in this research are a narrative of regret about their inability to maintain an acceptable work life balance. The narratives of Hidaya, Wiktoria, Chiamaka and Jenson here below were used to display this.

> *Throughout my working life within domiciliary care I have not had any holidays for myself, it has been working and working to pay my tuition fees, to meet my accommodation and living expenses [changes tone to almost a whisper]. It is not easy to combine full time studies and domiciliary care work and family life but then I need the money.* **Hidaya, Female, Tanzania.**

Hidaya is aware that there needs to be a balance in her time to allow for both work and recreation but unfortunately, the economic and academic pressures in her current student status as well as part time agency worker do not permit this. Trying to accommodate fragmented time and scholarly activities as well as other family responsibilities is a daunting task. Also given that Hidaya due to her student status is allowed only 20 hours per week, she is on agency employment as she requires flexibility around her student commitments. There is however no guarantee that the hours given will coincide perfectly with her schedule, so she also has to accept shifts even after a long day at college.

> *It is very hard to balance work and life because the hours that are offered are few and the pay is poor, it's not like in residential care, so I need to capitalize on the available hours to make my ends meet.* **Wiktoria, Female, Poland**

For Wiktoria the economic need drives her choices and she has adjusted herself to flexibly take on any shifts as may be obtainable to compensate for the few paid hours and the low pay offered within the domiciliary care sector.

On work life balance (laughs nervously). I try. With this work it is very challenging you know. Especially with the shift patterns because I also do work on alternate weekends. I rarely find my children awake by the time I get home in the evening. **Chiamaka, Female, Nigeria**.

The statement 'I try' is satirical and sarcastic. Chiamaka even laughs out aloud as she is making this statement. A brief history of her is that she is married and has two young children aged less than four years. She has worries about obtaining a reliable and affordable child minder, so shares the child minding responsibilities with her husband who does nights shifts while she takes on day shifts to help minimize on the need to pay for child care. She even specifies that she works alternate weekend in her demonstrating the tight work schedule she operates from.

Below is a vignette summarizing the effects of not having a work life balance from the voice of a domiciliary carer who though speaking for himself, but whose story and experience may be similar to that of a number of other participants.

> *Before you go into care think carefully. Make a plan [laughs] because if you don't make a plan you could end up with no family, all by yourself. It's partly your fault because you have been working too hard [giggles] to pay your bills to live the correct way and at the same time you are losing all your family life. That's why I would say; before you enter this kind of work, home care work make sure you have a plan. One of the great guys Albert Einstein said,' life is like a bike, to keep your balance you have got to keep on moving' So you have to watch what you are doing otherwise your whole life sometimes could go past you and you don't even know. All your kids are grown up and for instance you could be saying to them - which one is you. Because you haven't been seeing them. You have been working too hard.* **Jenson, Male Antigua.**

The next section is devoted to interview sentiments about the duty rota, which, though not a theme, was discussed by most of the migrants in detail as they were expressing how the domiciliary care work is structured, how they have to be proactive to get regular work shifts and how sometimes the Agency misuses the carers when it is a 'double up' and only one staff is available. So important was the rota that some carers stated that they save it on their phones to ensure they do not forget their shift times and venues. The researcher coined the phrase 'subjugation to the duty rota' to bring out the issues raised as part of the interviewees work experience. It is discussed here below.

Subjugation to the duty rota

The stories of the migrant domiciliary carers portray mixed opinions about the duty rota. For some the duty rota is a physical reminder of the contingent type of work they are engaged in, particularly since the travel time in between clients is not reflected therein, the breaks even if unpaid too. Some respondents expressed the view that it was used as a carrot and stick by the employer to reward the carers who they deem 'good' with shifts at convenient places and with 'good clients' while denying others shifts. Sometimes when the carer is unavailable for a shift but their name is slotted into a shift and they do not show up it causes tensions with the co-workers as it means having to cover that role. Service scheduling and time as a unit of account are interdependent and affect work rotas and staff pay. For both service users and staff, how the scheduling of service delivery interfaces with their daily lives and personal commitments is of prime importance. The importance of the rota and its use in managing and making sense of the fragmented time within domiciliary care is undeniable as shown in the selected extracts.

> *I also got to learn the hard way after a considerable span without getting allocated any shifts that for me to get more hours I needed to maintain a physical appearance at the office whether through texting, calling or if I was working near there take my time sheet in so that the staff allocating shifts could remember to give me shifts and more-so whenever there were new care packages. Out of sight out of mind they say.* **Lonut, Male, Romania.**

Reliability and availability are core requirements that employers in the care industry demand of their employees and in a bid to not be labelled unavailable and hence lose out on available shifts, leave, rest and recuperation are the last option in such employees' plans.

> *At times if you or your co-worker is late for a double-up assignment some unscrupulous agency managers will ask you to get along with it as you await your partner or even to complete the assignment on your own. This is very dangerous because for example if the client needs to be hoisted anything could go wrong.* **Chiamaka, Female, Nigeria.**

In concluding the theme, it can be said that looked at holistically time is indeterminate; it is a continued progress of existence and events encompassing the past, present and the future. With regards to domiciliary care almost everything revolves around time. It affects and impacts upon the quality of care provided. It is of concern to all the parties in domiciliary care delivery.

6.2.4 Safety concerns

Under this theme six vignettes were selected for analysis. The first one from Farzana is a case of a near miss, whereas the second by Hidaya portrays how dangerous working in the client's house can turn out to be. The third is an excerpt from Okoronkwo, a male domiciliary carer and was included to show a male workers experience of a type of an ''attack'' by a client. The fourth is by Awinja selected to show sexual assault. The fifth narrated by *Zandalinalani* has been included as it illustrates a safety concern from a mental and psychological angle. There were more stories similar to these considering that care work is performed in the home of the client who may sometimes die during the shift where the carer is on duty. The sixth told by Bimbola offers an example of the versatile nature of a domiciliary care worker's role and experience. The vignette by Bimbola is one of several other vignette that were not included; but nevertheless storied similar experiences.

> *So as I was hoovering the carpet she went and took the knife against me. Because my own nature I am very caring, you know I also didn't know about health and safety procedures because even if I had 3 days training it wasn't enough, I did not have enough experience. So what happened I just stopped the lady, - I mean, I couldn't just-, you know – did not want to fight with her because I knew she had a problem. I reported this to the office and from then on what did they say - they just said, ok. Don't go there anymore. And I think they took her to a special hospital. But I had not been told of the type of client I was confronted with. I could have been killed.* **Farzana, Female, Pakistan**.

Farzana is describing an incident where she was lone working with a new client who appears to have mental health issues though this was inadequately disclosed to Farzana before she was sent to provide the contracted care. Farzana saying '… ***did not want to fight with her because I knew she had a problem.'*** means that she did not blame the client for the action of attempting to knife her but attributed it to her mental health condition that had made her snap. She however feels that her agency was not very helpful from the onset through inadequate training on lone working, restraint and other health and safety related issues like for example deprivation of liberty. At least Farzana was not injured and lived to tell the agency of the incident. Such an occurrence is bound to have an implication on the psychological contract of this employee. For example, Farzana may feel that her Agency is more interested in covering shifts for the monetary gain ignoring the employee's safety concerns, she may also feel her work is devalued. The words she uses 'I could have been killed' do not only express a real fear but also anger at the dismissive attitude by the Agency upon her complaining about this incident.

I have been assaulted by a son of a female client I was caring for over allegations that I did not take instructions from him that are not part of the care plan. In this instance he wanted me to iron his clothes and he was not my client. I had politely told him that I had finished my allocated tasks and was going home well after the time allocated to me at his mother's residence. He slapped me and pulled me by my hair out of the residence. While outside, I immediately called my agency and informed them of this. They said they would take up the matter. I was substituted with another carer, lost hours as I was not offered another shift for quite some time. It made me feel like I was being punished for reporting the incident or like they thought I brought it up on myself. Until now when I am talking with you despite being in the employment of the same agency, I have never received any report on the outcome of this issue. I felt then and still feel very humiliated and let down by the agency – I wonder is it because I am an international student - I ask myself - could this be left unsolved if it was a home or EU worker? **Hidaya, Female, Tanzania.**

Hidaya is discussing an experience where she was physically assaulted by a son of the client who was also resident in the client's house. When performing domiciliary care, the carers can be confronted by scenarios where they have day to day contact with members of the client's family in the course of their duties. As explained by Hidaya, the care plan is followed with regards to itemising and guiding on the services that the carer is to provide. Often times some family members expect and even demand that the carer do work that is personal to the client family member and thereby not included in the care plan. Considering the time constraints and the complexities involved in taking instructions from multiple sources while performing their domiciliary care role within the clients' homes' this can sometimes lead to conflicts. Hidaya could have pressed charges against her attacker as she was assaulted in a place where she was rightfully in by virtue of the client's house being her designated work place, yet still the client's son was in his home too.

The indecision by the agency leading to no closure to date on the mentioned incident, coupled with the student immigration status Hidaya occupies disadvantaged her from seeking other redress. The statement '**I wonder is it because I am an international student - I ask myself - could this be left unsolved if it was a home or EU worker?** Here Hidaya, is echoing some of the expressions that other interviewees in this research alluded to. It shows the 'otherness' of the migrant domiciliary care workers. They are aware of being 'othered' and that this may be depicted through some of their day to day work life challenges. Migrants tend to look at what they consider to be different treatment through the lens of how this would be handled if it occurred to others who were in different migrant clusters or even bona fide natives. For

international students, the imbalance is evident from their being assessed as internal fee paying students, to the clauses on their restrictions to work and recourse to public funds. Having navigated all this, it is not surprising that Hidaya is thinking if this is not enough and will the being 'different' from others continue to manifest in her life experiences?

> *One day a client spilled all over me a full glass of juice when we were just about to go out [demonstrates the act of violently soaking him with an imaginary drink and shakes his body with his eyes closed to portray a chilling shivering in his body as he recalls this]. For this one day, I felt that the staff I was working with was not very appreciative of the fact that something like this had happened; they were offering me the Client's clothes to put on, which then I felt much degraded. But obviously that is something that happened.* **Okoronkwo, Male, Nigeria.**

For Okoronkwo, the incident of having a client splash a glass of juice at him calls for further interpretation. Though he uses the word spilled all over me, his facial and body language depict a violent act of the client soaking him wet and actually throwing the glass at him. For him the client's action was a side issue, the most offending/humiliating issue was the response by his co-workers where they were offering to give him the client's spare clothes to wear home. In this case though care work is regarded as a low status job and by extension the same is implied for those that perform it, Okoronkwo goes against the grain and sees this being undignified and below his status. Different workers (Okoronkwo and his co-workers) witnessed the incident but their reaction was totally different. For the co-workers it was a case of doing the best in a bad situation to help Okoronkwo get home after the shift, yet for Okoronkwo it involved his dignity which he felt was violated by his co-workers suggestion. It also goes to show how different people react to a situation and how some carers rate their worth vis a viz the care work they perform.

The next extract is the story by Awinja who was providing domiciliary care services for a bed bound female client who was living with her husband. The client remained in the bedroom until she was hoisted by the two carers and transferred to the living area where she could stay and socialise with her husband and be brought back and assisted into bed. The client's husband was an elderly man but he was able-bodied. He was always around when care was being provided to his wife, excusing himself when it was intimately personal care but nevertheless an integral part of the wife's day to day living experience. He was cordial with the two carers as they performed their tasks.

The man of the house did not necessarily interfere with the way we cared for his wife – our client but the problem was that over time he developed an interest in me and wanted to flirt. One day, he smacked my bottom in a sexually inappropriate and suggestive manner and I actually told him off in the presence of my co-worker, a fellow migrant, who was present during the episode. He did not take this kindly and said I should have been discreet and not embarrassed him openly. He smirked and told me that he thought he was doing me a favour by appreciating my beauty and that after all since I am Black, I should be grateful that a man of Asian origin like himself could have admiration for me. I felt very insulted and demeaned [grimaces to express pain and annoyance]. I reported this to the office, was removed from that particular job and I have never had feedback on the same even up-till the time of this interview. **Awinja, female, Kenya**.

The story of Awinja shows an example of the additional challenges women carers have to grapple with in the course of their work as domiciliary care workers. Awinja is recalling an incident where she was working for a client who lived with her husband. It was inevitable that she would come face to face with the husband of the client as he was also resident in the same house. Despite Awinja working in a double-up where there was a co-worker as they performed their duties, yet the man of the house dared to touch her in an inappropriate manner. The response of the man, '***He smirked and told me that he thought he was doing me a favour by appreciating my beauty and that after all since I am Black, I should be grateful that a man of Asian origin like himself could have admiration for me'.***

The researcher interprets the man's action to suggest racial, sexist and chauvinistic tendencies which may stem from his misunderstanding about care work, women performing care work as a paid employment where he sees it as an extension of domestic work that is performed by women. The lacklustre handling of this complaint by the employing agency and their not pursing this with the seriousness it deserved is a cause of distress to Awinja. It can further be suggested that despite domiciliary care being a formal labour process and one that has been commoditized, the early notions in the minds of people about it being associated with home-work still exist as the actions by this elderly man show. The next vignette exemplifies the safety concerns of a carer for both herself and her client. A number of research participants alluded to encountering various occupational health issues.

'I had a client with a learning disability who also was also physically challenged and required to use a wheelchair. I would use the bus with her in the wheelchair to take places. The bus-stop was a bit far; we could wait for a period of time to have the wheelchair space available. Some bus drivers just ignored us as they thought it was cumbersome to accommodate a wheelchair especially if there were already two baby

buggies on board. I had to come very early to overcome the transport hitches. My client would sometimes spit, bang, yell and pinch or box anyone within physical proximity to the wheelchair (including myself) causing public people to ask me to control her. The weight of the wheelchair was another issue of concern. After pushing it, I kept having shoulder blade aches and needed to take paracetamol for this'.

Here Jamila is talking about issues that address a transportation hitch she experienced while out in the community while enhancing the personal choices of the client to get out and about. As this was provided for in the care plan it was obligatory. Yet there are some unplanned hardships such as safely getting the client into the bus, ensuring her safety and that of other passengers near her. This may also result in working for extra unpaid hours. In the same narrative she discloses that operating the heavy wheelchair has a toll on her health. This is a health and safety issue which may require addressing through training (whether new or refresher) on manual handling and lifting. Other examples from the stories included having to operate faulty equipment that placed both the carer at risk, lack of appropriate protective clothing when performing tasks that involved handling bodily fluids discharge (for example saliva, sputum, pus and incontinent management which could perhaps lead to infections).

*I remember being instructed to give the last office to a client. In terms of my training there was nothing that had prepared me for this. It was really scary to prepare this person to be taken to the funeral home and I was expected to do it. I was not expected to say no. If I had been asked what I wanted, I would not have been the person to do this [shakes her head sadly]. Also in my culture, a female of my age is not allowed or expected to interact with dead bodies of those older than themselves. It is taboo! This experience haunts me to date. **Zandalinalani, Female, Zimbabwe.***

To interpret what Zandalinalani is describing, the researcher offers a brief history. One morning she went to her client's house where she had a key to let herself in as the client was immobile and could therefore not open the door for her. She noticed that the client was unresponsive to her good morning greeting. She touched the client and the client felt cold and stiff. She called the agency to inform them about this. The agency told her to call the ambulance. The ambulance crew came and stated that the client was dead. They left the body and said it would be collected later. The agency told her to in the meantime clean up the client as she would normally have done if the client was alive in preparation for the body being collected by the undertaker. This process of cleaning the client is what she is referring to as 'last office'.

176

While she brings in her socialization and cultural background into play, one cannot help but empathize with her situation where she is forced to do something that she is ill at ease with, which has lasting psycho-emotional effects on her even after it was over. It also appears that part of the ramifications of her job was not mentioned to her during her initial employment. Also it would have been expected that Zandalinalani should have been offered counselling services at the best and cost of her employer as this is obviously stemming from a work related issue. The fact that this has not been done speaks volumes about her agency and its attitude towards employees.

> *I recall an incident where I and my colleague went to clean a flea-infested house, there were three cats and two dogs in a two roomed house, the clients bedding had bedbugs and wood lice whilst the pets had ticks on them. Before we embarked on the job we had been given personal protective equipment that included plastic bin bags, disposable head caps, domestic gloves and loads of detergent but nothing had prepared us for the shock in store. We did the job but frankly, I could not sleep for several days after this. I kept on dreaming that the fleas were in my hair, clothes and in my house.* **Bimbola, Female, Nigeria.**

Bimbola is narrating about the challenges in performing domestic duties as part of the care role. Despite the Carer having a job description, (part of which includes the care plan though this is drafted by the care coordination team and is in most cases done without the input of the domiciliary carer) there are however additional roles that may crop up in the process of undertaking what would be domiciliary care provision. Some can be one off domestic cleaning jobs for clients who may have had no earlier eligibility for domestic support but who as a result of a deterioration in their circumstances require such help. Other homes may have gotten to their deplorable dirty conditions as a result of the client's hoarding and cluttering behaviour.

To understand Bimbola's story it is imperative that a background of her employment status is provided. Bimbola is employed by an agency as a domiciliary carer. The agency sometimes gets contracts to do what is referred to as 'bisque cleaning' within the domiciliary carer informal terminology to describe the cleaning of very dirty homes that would otherwise require commercial cleaning under different circumstances. Bisque cleaning is applicable where some clients on personal budgets are living in very filthy dirty conditions and a remedial action of doing a one-off cleaning as long term cleaning is being arranged for them perhaps as part of their soon to be negotiated and assessed care package.

Due to the competition for contracts some payroll agencies have made bisque cleaning an important part of the role their domiciliary carers can perform. The few and short shifts available within domiciliary care compel the carers to take on any available shifts even when the jobs to be undertaken are outside the conventionally understood chores. Bimbola and her colleague were contracted not to perform personal care but to clean up. From her description, it seems like the place was so filthy and a potential health hazard to both those doing the cleaning and even to the client. Being in need of a shift Bimbola had to reluctantly undertake the chore. A review of the paraphernalia provided.' *personal protective equipment that included plastic bin bags, disposable head caps, domestic gloves and loads of detergent….'* illustrates this. Bimbola's motivation in undertaking this particular job was economic, yet the consequences of her decision to perform the chore leave her with psycho-emotional distress. Bimbola is married and has young children. The statement '***We did the job but frankly, I could not sleep for several days after this. I kept on dreaming that the fleas were in my hair, clothes and in my house'*** can be explained as her fear about carrying in her clothes bugs from the dirty work place that could be spread to her home, thus affecting her family. The implications is that she has fear that the environmental conditions at her place of work can have adverse consequences on her home which is clean but at the risk of being contaminated by pests brought from her job.

In conclusion, the stories by most of the participants about concerns over safety at work were more to do with their fear of an assault taking place especially in cases where they were lone working, and also if they were dealing with clients with mental health problems and challenging behaviour. Most of the participants reported having suffered some perceived acts of violence both serious and minor for example being hit by clients with walking frames, suffering from broken fingers, black eyes from blows, scratches and being scalded with hot meals while undertaking their roles with a similar number complaining that they had received verbal insults and threats from their clients/client family members. They have learnt over time how to deal with the clients, to apply dialogue or take flight when the situation gets tricky. Given that they have a responsibility to ensure that they are not the subject of a complaint to ensure ability to work in the social care services, they avoid situations that can result in safeguarding concerns. That they feel the employer is more interested in maintaining the client (business) than in the welfare of the employee, the domiciliary carers appear to be vigilant to avoid cases where they suffer physical harm while in the course of their employment. Migrants are likely to avoid trouble at all costs as

they eke out a living and some may not be aware of their rights, and sometimes even when they are aware, they may decide not to pursue the rights and intend put up with the situation. It is imperative to acknowledge that narratives by their very nature may have the unintended effect of encouraging respondents to deal with critical and unusual incidents in recalling their experiences. Some of these occurrences may be one-off experiences but having entrenched themselves greatly into the participant's mind that they warranted a storying.

6.2.5 Disquiet about the training offered

An analysis of the narratives showed that training was very important in the day to day execution of a domiciliary care worker's job. The views on the adequacy and relevance of the training provided at pre -employment and during the job shadowing and orientation process is discussed under this theme. The general feeling was that training within the domiciliary care sector should be provided and paid for by the employer and that employees should be offered conducive hours within which to train. The participants felt that lack of proper training also impacted on quality of care and could sometimes also lead to health and safety concerns. Employer initiated training also offers an opportunity for domiciliary care staff to bond with their co-workers some whom they hardly see in the course of their day to day working lives due to time constraints and also the vastness of the area domiciliary carers cover.

Training may also send a message to the workers that the employer cares about them. Every participant commented about their training in their stories. Due to the low status and value attached to domiciliary care work and by extension the migrants who form a large numbers of the workers in this sector, there is a tendency to ignore the training needs or the need to train those employed to perform domiciliary care work. Much of the training offered is on health and safety congruent to a study by Wills (2003) on the frontline of care at Tower Hamlets, and the responsibility for any other training as regards employability being the responsibility of individual employees similar to findings by Nickson et al., (2003).

179

Excerpts from the stories of Balkissa, Awinja, Angelo, Salieu and Guisippe below provide critical incident reflection accounts on their experiences on training /lack of training.

> *I was given some basic health care training which included hygienic training, manual handling, introduced to the kind of ailments and sicknesses that one can find themselves exposed to in care work and how one could protect themselves by working from an approach of hygiene. Also trained on the importance of confidentiality in this industry.* **Balkissa, Female, Cameroon.**

Participants indicated that the pre-employment training they were offered was mostly sketchy and theoretical. They were told that the practical elements would be learnt on the ground initially through job shadowing and experientially as they grew into their roles. A majority of those interviewed gave stories about bad experiences in their job shadowing encounters. Below is a vignette from Awinja's story that is quintessential of other participant stories.

> *On my first day as a domiciliary care worker, the Agency texted me an address, rota with timings and directions to a client's home. I was to job shadow two carers. There were no other details availed to me. I had never done this type of job before. The two ladies were of Western African origin, were bullish, brutish and spoke very loudly and it was hard to differentiate when it was normal conversation or scolding. I was slow and fearful and sometimes forgot the instructions they had given me and at this point I had not seen what I later got to know is the care plan which would have made my job and life much easier.* **Awinja, Female, Kenya.**

Awinja was new to domiciliary care work, she was going to a client she had never met before; she was also to job shadow two work mates she had never met before. The care plan for the client was in the client's residence and Awinja had not seen this before. She also had to find her way to the texted address. Her first day at work was traumatic.

> *In domiciliary care, trainings are offered at the onset of the employment, unlike in residential or nursing care where more technical training with annual refresher courses is a mandatory requirement for all staff and this is one of the concerns for inspection by CQC. In terms of training, I wouldn't say that I got great training. In domiciliary care there is no follow up to the initial pre-entry training.* **Angelo, Male, Phillipines.**

Angelo has been working in the care sector for three years. He has had an opportunity to work in both domiciliary and residential settings. He was a domiciliary worker at the time of this interview. He was commenting about the discrepancy in the training in two divisions that are within the social care sector. Angelo's story is similar to those of others who said that they felt training given under residential services was intensive and thorough. It was also regularly updated with issuance of certificates one could use in a future job search.

The closest I have been to having my skills improved is the training that social services organize. I even wonder what the role of my agency is in all this as I have never been trained by them. **Salieu, Female, Sierra Leone.**

Salieu has worked in the care sector for five years. Based on her continued stay in the United Kingdom she is eligible for recourse to public funds and therefore benefits from trainings that are sponsored by the social services department. She is employed by an independent domiciliary care agency. Immigration status can affect migrant workers training prospects either way.

In my current employment with the assisted living, I have mandatory online trainings and the CQC when conducting inspections check on staff training records. This is not however the case when I am doing my other job in a client's home with the domiciliary care agency. There only minimum training that is job specific to enable you perform the immediate job is given. No transferable skills. This impacts on the ability to progress within the domiciliary sector and is also a demotivating factor **Guisippe, Male, Italy**

The comments by Guisippe suggest an inconsistency in training within the domiciliary care sector.

Recapping on the training theme, the above findings are indicative of employee initiated training premised on what the employer determines as relevant to satisfy statutory compliance requirements, or perhaps, that which equips the employee with the necessary basic skills to perform the care role.This may be the reason why it is unstructured and hard to enforce. Though implicit, these domiciliary care workers were found to attach a lot of importance to training. For them training was seen as for equipping them with skills, some usable in other forms of employment, so when they deemed the training provided by the employer subservient to their past or future qualifications and attainments, they were likely to ignore it.

Outcomes on National Vocational Qualifications and other accredited courses

This section will present the findings the participants' views about National Vocational Qualifications (NVQ's) and other social care related courses. In England there is great emphasis on the acquisition of NVQ's as a minimum to perform certain jobs. Domiciliary care is one such job. Currently it is preferred that a care assistant (the lowest rung within social care provision) should hold at minimum an NVQ level 2 to obtain employment. However, one may be offered employment even without this qualification but it is expected that they will work towards obtaining this in the course of their employment. Available literature has suggested that migrants

working in low sector jobs are likely to have higher qualifications than this requirement (See Baunder, 2000; Kreyenfeld and Konitzka, 2002; MacKenzie and Forde, 2007). Some employers do indeed employ migrants who do not have these qualifications, as long as they possess educational attainments that would be viewed commensurate with or higher than the level 2 requirement. Given that there are fewer opportunities for career progression within the domiciliary care sector as the stories of the participants alluded to, the employers are not afraid that the migrants may demand promotion. A good number of the migrants come from countries where educational attainments supersede any vocational training. They therefore are at odds with the requirement and emphasis on the NVQ'S and some of them see no relevance in undertaking the certification trainings as it amounts to deskilling.

The stories of Musim, Omoyotosin, Ruwaihim and Austeja were used to portray many participants' views on Level 2 being considered a minimum qualification for entry into non-skilled care work.

> *I got into the job with no qualifications before I came into the job. I had a first degree from my home country. And like I told you earlier I came here to do my studies. So I think the minimum benchmark for a care job which is NVQ2 I exceeded it and the company thought I could do in-house trainings to build up my skills to deliver on the job. So my induction was part of the in-house training.* **Musim, Male, Egypt**.

> *So, interestingly in the course of my work as a care worker I have not taken any NVQ's because I found myself restricted. Let me tell you why I say that I found myself restricted. The place that I worked they said that because I am an international student, the company policy would not allow them to train me on NVQ's because that will be seen as – you know- like for example- well my visa has some clause – one of the clauses include - No recourse to public funds. So if I can interpret that very well, it means that if the organization trains me, I am benefiting from the public funds which in some ways make you to an extent separate yourself from the job. You know, because well… If I am just doing a job to earn a living what's the point of investing to grow on the job? So, as I can tell you I have done the job for a long time and I don't have any qualifications that are geared towards growth in the sector.* **Omoyotosin, Male, Nigeria.**

> *The requirement about NVQ's is punitive for new migrants whose residence restrictions do not allow for government supported training unless they have been in this country for a number of years, I am not sure whether it is three or five? It is expensive and most of the new migrants are living from hand to mouth so such training is the least concern for them.* **Ruwaihim, Male Pakistan.**

The excerpts from Omoyotosin and Ruwaihim demonstrate that one's immigration status affects the vocational training prospects of some domiciliary carers. If training is the responsibility of the employee and if there are no incentives for it, employees may adopt a lacklustre attitude towards it. This is a case of the employee bearing unduly the responsibility for training whose onus was on the employer under the old psychological contract.

Austeja's comments below show the link between whether one intends to pursue domiciliary care as a career and their willingness to take advantage of available training opportunities and the timing at which this training is arranged. For most migrants who see domiciliary care as a transitional job then additional training beyond the bare minimum makes no sense. Where attaining qualifications required for working in an industry is part of tangible employee development systems, employees buy into the need to obtain the qualifications and may even be willing to self- fund. The lack of synchronicity in the organizational and Austeja's view on NVQ'S led to her discontinuing NVQ training as explained below.

> *Anyway, I had started the NVQ once but I wasn't interested because there was no support at all, the way they put the hours it wasn't convenient for me. Since I am not intending to grow into domiciliary care there is no need to invest in any formal qualifications. I tend to rely on any in-house courses as offered if they fit within my time. **Austeja, Female Lithuania.***

In presenting the findings on National Vocational Qualifications, it is worth noting that forty three of the research participants indicated they did not have the level 2 minimum requirement. The only participant who held a level 2 was Kelechi (who is currently a commissioner with the Care Quality Commission and she expressly stated that she obtained this qualification when she purposed to move away from domiciliary care into residential care sector where this qualification was mandatory for promotion and senior job roles). She has advanced her professional training to impressive levels. The researcher included some excerpts of Kelechi narrating her training and development journey.

> *At that point I applied to do a Masters in Occupational Therapy. I got offered a place in a university in London bit I couldn't proceed to do it because I didn't have indefinite stay. And they didn't accept self-funders. You needed to be sponsored by the NHS. And to be sponsored you needed to have the indefinite stay so I got pulled out from the course eventually.*

I also applied to do social work, the same issue and finally I thought – You know what… At this point I will just wait until I have my indefinite stay before I can progress or just-let me focus on the job. A lot of us migrants want to wait - they wait- they would rather wait 10 years for the company to sponsor them rather than go and do the course. So I wasn't waiting for anyone to sponsor me… So I did the NVQ Level 4 in Care, NVQ Level 4 in Management. I did Project Management Course Certification, then I did a Masters in Health and Social Care. And I was doing all these courses while I was working as well. It was challenging but the reward has been great so I have no regret at all.

Concisely, the migrant domiciliary care workers did not have much regard for the NVQ2 requirement for those engaging in care work. They felt that if this was to be applied then it would be useful for those in residential, nursing and other forms of care work under the National Health Service where they felt there was room for professional development. For them they had reached their apex in the low pay domiciliary care job. They therefore saw no need to be subjected to this vocational training. Bearing in mind, that a good number of these interviewees came from countries where there was emphasis on academic qualifications to ensure ability to compete for the scarce jobs in their countries of origin, this was not surprising.

The following vignettes show the views Alayna, Okoronkwo, Zandalinalani and Bimbola on domiciliary care work and progressing within the sector as there is no defined structure for further promotional opportunities. Though indirectly related to the disquiet on the training provided, they have been included as they contain data that will inform opinions on discussion of the findings.

Alayna has been a carer for four years and states that there is no hope or scope for any progression hence her assertion that domiciliary care is not a career.

I wouldn't consider this job as a career, I mean you can do it even as a volunteer, you know [changes her tone to a mixture of sorrow and remorse] if you want but not as a career. No, it's really difficult because I don't see myself progressing unless if you think maybe going into nursing or being a manager of your own home care agency. **Alayna, Female, Cote d'Ivoire.**

Okoronkwo has lived in the UK for eight years, five of which he has been a Carer. His immigration status affects his ability to make it his career. Okoronkwo is pursuing a post graduate degree alongside this work. He has aspirations of one day serving in a managerial position which he sees he cannot attain in this type of job.

*So I don't see myself as having a future in the care industry because there are obvious limitations to growth. And I can't even do – or grow as a manager because that means I have to do more than 20 hours which will exceed the condition of my visa. So I think in this job you are more or less having to choose between survival and a career. And the question you ask yourself is, is it an area you actually want to have a career in? And I think I can tell you, sorry, to say, but this is not an area I wish to have a career in because of the limitations that I have seen in this industry. **Okoronkwo, Male, Nigeria.***

Zandalinalani*,* talked about stagnation in the job. She has worked in this industry for eight years at the same level. She has brought in the dimension of a 'migrant' into the story. Interpreted this suggests that she is implying that other migrants may suffer a similar fate if chose to undertake domiciliary care.

*I would not recommend any migrant to venture into domiciliary care if they are interested in a career within the social and health care industry. Because one thing you do not move professionally here. I am just where I started. **Zandalinalani, Female, Zimbabwe.***

Bimbola with six years' experience in care work sees her current role as job that has equipped her with transferable skills that she can put into use when she eventually goes back to further education after her young children have gone into full time education. This is a transitional job that soothes her immediate needs.

*I do not see myself as making a career out of this job. I anticipate to undertake a degree course in social work as this is my passion. I believe I can make a better contribution toward policy and improvement of the social services sector given my experiences in the domiciliary care sector. I hope to commence my studies when all my children have reached the age of going into school for full day. **Bimbola, Female, Nigeria.***

6.3 In summary

This chapter briefly explained the process undertaken in the data analysis to obtain the findings that are presented herein. These include a recap on characteristics of the research participants, the story of the migrant domiciliary care workers entry into care work as well as the interview question. The five themes obtained through a thematic analysis and then subjected to Interpretative Phenomenological Analysis and Hermeneutic Phenomenology methods for analysis and interpretation. The themes have been provided using selected vignettes presented textually from the verbatim audio-recorded interviews. The three objectives of the research have been restated to allow for flow within the chapter. Two of the research objectives were logically blended in the findings to report what the migrant domiciliary care workers said.

CHAPTER SEVEN

FINDINGS AND DISCUSSION (CONTINUED): THE NARRATIVES IN RELATION TO PSYCHOLOGICIAL CONTRACTS AND OTHER ISSUES

7.1 Introduction

Here below findings of the third objective - to use the work experiences of migrant domiciliary care workers to scrutinize their psychological contract. The research approach adopted here does not measure the psychological contract using the scales and measures applied in an etic study and so neither contradicts nor infringes on the inductive stance of Interpretative Phenomenological Analysis studies. The migrant domiciliary care workers narratives of their experience will be subjected to analysis using thepsychological contract and psychological contract literature. It is important to note that there will be reference from the above quoted vignettes as well as comments from paraphrased sentiments of other research participants as it is also a part of their voice and work experiences. This part will offer and illustrate the emic qualitative descriptions of the idiosyncratic meaning given to the employment experiences of the interviewed migrant domiciliary care workers based on inferences of the possible forms of ensuing psychological contract. The intent of this is to explicate the third research objective. The emic interpretation of these experiences has been offered as have important findings touching on pertinent psychological contract definitions. Last but not least under a section titled other broad spectrum findings, gender relations, trade union membership and multiple portrayals of the 'employer' findings have been provided to augment and tie up the three research objectives.

7.1.1 Findings on the Psychological types

The findings of the research were that most of the research participants were likely to be holding a transactional psychological contract. Some of the vignettes indicating this include that of Nasra (where carers speak in their native language while attending to a client who obviously is of a different dialect), Jenson (on anger about the specific demand by clients for carers who speak particular languages), bias in the allocation of shifts (Okoronwo). It was found that any form of feeling that one has suffered a form of prejudice may lead to the complainant holding a transactional contract. This was not so only with regards to prejudice from the clients but even

from their co-workers as many stories showed (examples being Saifatou, Kemi and Nasra as well as others whose stories were interpreted but not included in the vignettes).

It was found that issues around the theme of time constraints also suggested the presence of a transactional contract. Those who had concerns about health and safety issues may be holding transactional contracts and continue to perform their duties despite their concerns due to an economic motivation, that of eking a living. The zero hour contracts whether voluntary or involuntary imply the existence of a transactional contract while one is undertaking their roles as do leave where one may overwork to cover for periods when they have no shifts to keep afloat financially. It can be argued that in instances where employers use the lack of clarity about leave for workers on zero hour contracts to lead to the workers holding a transactional contract. The subjugation to the rota is also indicative of the existence of a transactional contract. On the theme on disquiet about the training offered again illustrated a transactional contract (training will be discussed further under breach below). Most interviewees did not seem to attach much regard to NVQ qualifications given the lack of career progress and that some saw care as more experiential than academic driven. In summary the following features ascribed to transactional psychological contracts were confirmed from the stories which show: low affective commitment (Rousseau and Parks, 1993; Irving and Bobocel, 2002), static duties, written role information and a narrow influence where the conditions are public and observable, offer easy exit, little learning and the use of existing skills (Freese and Schalk, 2008), as well as the calculative nature [time calculations] and little flexibility (Dabos and Rousseau, 2004; Chambel and Castanheira, 2006).

The following extracts typify the findings about many of the repondents views and conclude this section on transactional psychological contracts.

> '*I am at home with care work but its not a career I would choose. I see it just as a job to make my ends meet*' **Okoronkwo, Male, Nigeria**.

> '*I do this job for sustenance and for lack of another suitable one; otherwise I would not be in it*' **Iker, Male, Spain.**

Next, are the findings regarding relational psychological contracts. Importantly, none of the elements associated with the relational psychological contract as espoused by Robinson and Rousseau, 1994 (see also Rousseau, 2000; George, 2009) appear in the accounts of the research

participants. These include that the employer commits to stable wages and long term employment and that considerable investment is made by both parties and that it focuses on both economic and emotional aspects. The employers of the migrant domiciliary care workers did not offer long-term employment and though there was expectation that a stable wage be maintained, the erratic shifts affected this.

Based on the findings, it can be concluded that none of the participants' stories alluded to their holding a relational contract. The work experiences and tensions therein as described prevented the formation and nurturing of such a contract. The desire by some carers to perform their duties with due diligence or some altruistic motivations should not be confused with holding a relational contract. One of the characteristic of Rousseau's relational contract is that the parties in an employment relationship make considerable investments emotionally and economically. However, the stories of many interviewees alluded to the impression that they felt they had involuntarily invested more. The extracts are indicative of such.

> *Sometimes you struggle to have the second person, you put yourself at risk coz you are now in the position- you will be thinking about the client's safety- if I don't put this client to bed they will remain on their chair all night and in my conscience I would not want to do that, so most of us will put ourselves at risk. So you say, let me risk to use the hoist on my own or lift the person- meanwhile you are causing injury to yourself- your back.* ***Ruwaihim, Male, Bangladesh.***

> *One time I was alone as my double-up did not show up for the bed time call. I called the office and they told me to try and safely hoist the client on my own as they had no replacement. The hoist jammed. I could not get them out. For 15 minutes I was very scared and confused thinking that this may result in a safeguarding issue. Mercifully, it finally worked. This was very scary.* ***Jenson, Male, Antigua.***

Concerning the third type, the transitional psychological contract, the stories of all the participants on student visas alluded to their holding such a contract (transitional because they saw it as short-term with the work to be undertaken during specific times in their student tenure and in fcompliancet with Home Office Immigration requirements). Many of them hoped to return to their country of origin upon completion of their studies and for a few, per adventure if they found themselves staying on after obtaining different immigration status, they intimated they would look for jobs commensurate with their educational attainments and not in domiciliary care work. It was however not exactly as defined in psychological contract literature as prone in

organizations that are closing down, with no explicit performance demands and with high levels of mistrust and uncertainty (Rousseau, 2004, Jepson and Rodwell, 2012). The research was not on an organization but it is important to note that the psychological contract can be used to study all types of relationships. There are explicit performance demands on the care workers in the care plan. Those on student visas were found to have high levels of trust and did not exhibit uncertaintly therby negating the claim by Rousseau (2004) and (Jepson and Rodwell, 2012). Apart from those with restrictions on their working hours, others who could be can be said to be holding a transitional contract were those who saw the job as temporary and held on to it as they actively looked for another job.This included those who were waiting for completion of their adaptation processes to practice their professional jobs and those who were whiling away time as they waited to get indefinite leave to remain where they could then transition into other jobs. The vignettes below are indicative of the aforesaid.

> *'The reason why I do not proudly wear my uniform and have to cover it up is because I do not see myself as doing this job all my life, I do it on and off'.* **Alayna, Female, Cote d'Ivoire.**

> *I do this job as I wait to get my indefinite Leave to Remain in the UK. Also, I hope to commence my social work studies when all my children have reached the age of going into school for a full day.* **Balkissa, Female, Cameroun.**

Others also held a transactional contract at one point but changed into embracing a transitional contract instead of quitting when they felt there was a breach or violation as they weighed their options. The researcher opines based on elaborated findings, that they found a different kind of transitional contract from the one in mean stream psychological contract literature. This claim calls for further scholarly investigation in future research on transitional psychological contracts.

Lastly, is the balanced psychological contract. The stories of the participants' on their work experiences did not show evidence that any of them held this type of contract. A summary of the main features of a balanced contract is that it is based on the economic success of organizations and employees opportunities to develop themselves in their career (Rousseau and Wade-Benzoni, 1994), on performance and contributions to firms competitive advantages due to market pressures (Rousseau, 2000) and a recognition of the future internal and external employability and the changing nature of work (Fugate et al., 2004; Van Der Heije and Van Der Heiijden,

2006). The assertion of internal employability within the current employment is not assured and the migrant domiciliary care workers external employability is based on the notion that they can move to other low pay jobs within the same sector not for professional development. The finding of the absence of a balanced psychological contract among this group of carers is not surprising given the multi-foci employment relations, changes in the social care sector and their migrant status.

It is worth pointing out that analysis of narratives about the work experiences of those migrant domiciliary care workers who have served for a period between 1 and 5 years suggested that they were likely to be holding both transactional- transitional psychological contracts. (see table 2 on the basic participant demographic information for their particulars). Their paraphrased stories told about their perceptions that this was the job they could easily obtain at that point and they looed forward to moving on to other jobs when they became better acquainted with the dynamics of job hunting in the UK adequate social capital skills.

To conclude the findings on the type of contract that the data analysis suggested it is worth noting that the transactional-relational contracts are a continuum. Depending on what is being investigated, findings can show different results. For example, whilst training can be classified as falling under a relational contract, it can also be considered a transactional one - especially where training is only for the acquisition of job specific skills to aid in job execution

Though research suggests that breach leads to employees decreasing their positive (Conway, Keifer, Hartley and Briner, 2014) and increasing their negative (Bordia et al., 2008 Jenson et al., 2010) the scenario of the migrant domiciliary care workers interviewed is somewhat different. For example the migrant domiciliary care workers expect to be paid for contact time and to perform duties premised on argument that the psychological contract is individually and perceptually beheld. If employer practice turns out to be different, there is a feeling of breach. However when this habitually the norm, most care workers did not react exactly as per findings by the aforementioned researchers (see ibid, 2014 and ibid, 2010). There was a slight modification in behavioural reponses. This may be attributed to workers being aware that any misdeameanour or deviation from the care plan if caught out may have grave repurcussions not

only in loss of job hours but also in criminal prosecution and an inability to work among vulnerable adults if a felony is recorded against them and gets the attention of the Data Barring Services. Those who may have wished to be in a cordial relation while undertaing their care giving roles responded to just performing to the bare minimum expected standards in such circumstances.They could for example leave non-health tratening tasks incomplete if their allowable shift time elapsed before some chores were undertaken (for example leave dishes in the sink uncleaned or leave clothes in the washing mashing if the cycle has not ended by the time of their shift ends.The vignette below portrays an example of an employee's response.

> *'I kept my professional distance as admonished during my induction that my work ends with delivery to the service user. As a migrant I saw the need to do my best in the job and to be careful with regards to doing anything that would jeopardize my stay in the UK – especially for the sake of references should I need to move on from this job'.* **Omoyotosin, male, Nigeria.**

The low fulfilment depicted in the stories of a number of participants is a form of response to a breach of contract (Rigotti, 2009) but they have not quit their jobs due to this, They continue to hang on by engaging in continuance commitment until other jobs crop up. Below is an illustration of one such vignette.

> *In one of my employments, my client lived alone and had a dog. Her family lived near her and was expected to walk the dog and clean after it daily as they used to visit daily. However over time I realized that even if they came they did not walk the dog. Consequently the dog would wee and pooh on the carpet, in hidden corners, on the seats and sometimes when I was changing the client, I could see that the dog had pooed on the bed. I could not leave the client in this filth, I had to clean it up, clean after the dog and this was very demeaning. I complained to my agency and they told me that it was beyond their control and that it was in my best interests for the agency to retain that client as a loss of that client would mean I would lose employment as this was my only client. I grudgingly continued to do these chores until when the lady was moved into residential accommodation.* **Wiktoria, Female Poland.**

Lastly, a number of interviewees from the narratives it can be concluded that carers can face different sets of expectations from different employers and different clients and that therefore they may have multiple Psychological Contracts in relation to these different 'others'. Moreover the expectations of carer and client or employer can conflict (e.g. carer expects to follow care plan, client or client's relative wants more and the employer (sending agency) wants to maintain the business irrespective of any friction between the carer and the client?).

7.1.2 Findings compared to the established psychological contract literature

As mentioned earlier in the chapter introductory paragraph 7.1 above, the researcher will now turn to the literature that was upheld or negated about psychological contract at its inception and during the fifty or more years within which the construct has existed. The participants' stories confirmed that psychological contracts are largely implicit and unspoken as proposed by Levinson et al., (1962) and that individual employees are the holders of expectations dissimilar those in the study by Argyris (1960) who emphasized the group's attitudes stemming from shared objectives and measurable tasks. The study population in both researches was however different as those of Argyris were drawn from an organizational setting whilst those in this research were from different organizations and the study was not an ethnography. Similar to Robinson and Rousseau (1994) and Rousseau and Tijoriwala (1998) it was determined that all expectations constitute a psychological contract. It was confirmed that expectations predate current employments and that the employees hold on to them to interpret new employment experiences, which corroborated Schein (1980) and Roehling (1997). In this study the argument about whether an organization can hold a psychological contract was resolved through the migrant domiciliary care workers' stories and it can be proposed that the assertion by Herriot, Manning and Kidd (1997) that only individuals can hold psychological contract holds.

It was also affirmed similar to Rousseau (1989) that agreement between the parties is not required for the enactment and existence of a psychological contract and and that an employee can simultaneously hold more than one psychological contract (comparable to Marks, 2000).

This study found that employees' psychological contracts are shaped by their experiences within the organization and not by organizations thereby contradicting the views by Beardwell, Holden and Clayton (2004) that employee psychological contracts are shaped by the organization. The dynamic and changeable nature and need for re-negotiation of the psychological contract was evident, corresponding to Rousseau and Schalk, 2000 and Thomas, Av and Ravlin (2003).

The interviewees were found to individually hold a new psychological contract where they are responsible for their own career development with a commitment to work replacing that to the organization, confirming Stroh, Brett and O'Reilly, 1994; Kissler, 1994, Parks and Kidder, 1990). The following extracts are availed to show the views of many of the interviewees who self-funded for training out of their own initiative.

> *Since the agency did not pay for external job related trainings, I inquired online and paid for some courses to boost my changes of moving into other care roles within the social care sector when shifts are not forthcoming some basic qualification to get shifts.* **Shema, Female, Bangladesh.**

> *I decided to go to college. I started seeing things differently, those that I had earlier on ignored. I.e. manual handling, handling clients inappropriately, I understood episodes of bullying. I started challenging them. This culminated in my being offered fewer and finally no shifts. But the training I had invested in made me get jobs within supported living services which is better paying.* **Cheyenne, Female, Belize.**

A surprising finding was that for the migrant domiciliary care workers interviewed, promises seemed to be peripheral in comparison with expectations. This may perhaps be due to the type of employment since shifts are also dependent on the commissioned hours that the employer has managed to obtain. Little wonder that they responded to incidents that would have been construed to border on breach or violation, sometimes in a nonchalant manner. Another notable characteristic of domiciliary care is that not much is 'promised' to the worker at the point of entry into the employment relationship; it is the repetitive behaviour that was found to inform employee expectations. The two excerpts hereunder denote the feelings of a good number of participants' reponse on matters for which they would legally be entitled that they are not enjoying.

> *Zero hours are used by people who use the system because the system- the government has made it legal so you can use this kind of stuff. Many people have suffered over the years, you work, no holidays, no benefits, if you are sick, you wait until you get better to resume work to start being paid for the hours you will now work. Frankly, I don't care.* **Dominykas, Male, Lithuania.**

> *In a good number of my employments with the agency I am not paid any leave allowance. They say I am not entitled to leave as I am considered a part time worker. I am not sure if this is legally right, but for me, I just need to have my pay for the hours I have worked, so I do not concern myself with leave pay issues.* **Omoyotosin, Male, Nigeria.**

7.2 Other Broad-Spectrum Findings

It had been expressed earlier in chapter 4 that gender and trade unions would be of interest in this research, given that social care is highly engendered and that from available literature discussed in chapter 4 most migrant workers do not belong to trade unions. The decision to deal with two separately below is that gender relations (and the employers' role) is an issue that cut across many of the themes discussed above and in the case of trade unions was that it was conspicuous by its absence in the respondent's narratives. The question on who the other parties in the psychological contract are has been a topic of debate ever since the inception of the psychological contract construct. In the case of the domiciliary care workers interviewed in this research, interesting versions were adduced as to whom they thought to be their employer, who then would be conversely a party in their psychological contract. Sections 7.2.1 and 7.2.2 will discuss gender relations and trade unions respectively. Section 7.2.3 will offer the participants view.

7.2.1 Gender relations

Gender (the care workers gender) was found to play a role in defining their lived work experiences. This was in their relations with their clients and also as they co-worked with members of a different gender. It is likely that men who require care are culturally attuned to women acting as carers, whether as mothers, sisters or other female relatives being responsible for taking care of children and the sickly. A man in need of care will see himself falling into this category and may believe a female carer will be best suited for his condition and in doing so deny willing and available male domiciliary carers' a job. So this may suggest that the presence of more women than men in the domiciliary care industry may be dictated by client and industry led preferences.

A summation of the views by male participants on gender relations was that they are consciously aware that the industry they work in is highly gendered, that both the female clients and female co-workers have an upper hand on how things are run and that men do not benefit from 'tokenism' by virtue of being in the minority in this employment sector. However, Jenson's vignette concludes that care giving should be viewed using gender neutral lenses and does using an interesting quote

'*Caring is like music, it's a language that anyone should know, cos it's caring, it's not something that you need to go to college or to university to learn about. Caring is a basic thing that starts from when you are young and you see your mother is washing you or your siblings and then you can see- that's personal care. So, it's really not a difficult thing to do as long as you do the right thing, not the wrong thing, then caring is quite easy. It is for all people. If you have any good in you, you can be a Carer. Not necessarily for women. It is only having babies that women do that men don't. Caring is for carers whoever you are. It is like parenting. Once a man twice a child'*. **Jenson, Male, Antigua.**

Next are the summarized views of the female migrant domiciliary care workers. The female participants in commenting talked about the masculine features associated with the male gender such as physical dexterity, which they felt the male co-workers offered with ease, but they felt that men shied away from what they considered to be feminine tasks and those men were generally punctual and serious when performing their duties. Overall a vast majority of the female participants saw men as an integral part of the domiciliary and other care sector. They did not seem to mind performing their care roles on male clients but preferred to do this in double-ups with male co-workers to offer them some buffer against possible assault. In conclusion, both male and female interviewees can be assumed to hold transactional and transitional psychological contracts not necessarily emanating from their gender, but due to job characteristics and the interactional relations at work. Findings of this research therefore suggest gender neutral psychological contracts.

7.2.2 Trade Union Membership

The findings were that most domiciliary workers interviewed do not belong to any trade unions as only three out of those interviewed stated they were members of a union. The following vignettes demonstrate the views of three who were unionized.

I approached the union and subscribed for membership recently. After the new changes in social care, I felt vulnerable and uncomfortable. The union can fight for me. For example if I am sacked when unwell or if a client overdoses and lands me in trouble… I may even be jailed. The union can put forward some of these matters on my behalf. **Zandalinalani, Female, Zimbabwe.**

My background suggested that unions were not good. In retrospect my agency once went burst, I lost money, have been summarily dismissed for minor issues owing to my being an agency staff. Union would have assisted me over these undemocratic dismissal had I been a member then. Now I am a member of UNITE to protect myself. **Jenson, Male Antigua**.

I was encouraged to join the union by my colleagues in supported living services where my agency sometimes sends me to cover shifts. I have so far not had an opportunity to benefit from my union membership, but if need arises, I can count on their help. **Murage, Male, Kenya.**

Below are abridged findings representing the stories of those who were un-unionized. According to most participants there is a lack of clear information about the role of unions and the conditions for membership, that the unions have not been proactive in recruiting from the sector these participants work in and that there is a general apathy towards unionization among the migrant domiciliary care workers as interviewed. The general opinion of many of these migrant domiciliary workers was that unions should be left for indigenous people whom they considered litigious. Many of them did not think that unions have regard for migrants and hence did not see how they could benefit from union membership.

7.2.3 Multiple portrayals of the 'employer'

Based on a combination of the three research objectives and that it is important to try and gain some insight into the other parties in an employee's psychological contract this finding has been included. Though the actual verbatim extracts are not presented herein (this may be done in projected forthcoming journal articles) there are abridged expositions from the data analysis that would be of interest to the reader.

Direct local authority employees were crystal clear on the identity of their employer. A few others who were previously employees of the local authority but who had been retrenched following the recent changes were in obscurity or denial about who their employer was.

They were working as agency workers with independent providers but looked to local authorities as the masters that commissioned the client hours thereby indirectly having a stake in their employment. As the study participants were not drawn from one particular organization and due to their complex employment setup this was not unexpected. Briefly, some thought their employer was the Agency that gave them the work shift and consequently sent them to the particular client, for others there was a blurred confusion on whom between the agency and client, others mentioned thinking the client's family had an important role in their continued employment and therefore were part of the employer team.

A distinct group was those who were introduced to the client by the payroll agencies and they indicated that their first allegiance was to the payroll agency as it was the agency that had connected them to the personalized budget holder in whose house and for whom they now work. The payroll agency collects payment from the budget holder and pays the carer after deducting a payroll administration fee. The job designation for this group of carers was Personal Assistant and they tended to do administrative, companionship and therapeutic roles for their clients with minimal personal care services.

To conclude the findings on whom the interviewees considered their employer, it can be surmised that it is possible to hold more than one psychological contract at one time and with different 'employers' or 'parties' to what one considers their employment relationship, as long as they perceive that a promissory exchange relation is in existence. So whether it is clear who the other party is or not, a psychological contract exists about employment relationships and this can be corroborated by the fact that the psychological contract is in the mind of the beholder.

7.3 In Summary

Earlier in chapter six in a bid to provide a thorough analysis and interpretation of the data, cognizant of Interpretative Phenomenological Analysis and Hermeneutic Phenomenology methods core themes and their sub-themes were presented. The five themes; Challenges with communication; Prejudice; Time constraints, Safety concerns and Disquiet about the training provided encapsulate the interviewees answers to the research question and the first two research objectives through general discussions of the analysis of the narratives. In this chapter more detailed discussions and a peek at some other important topics established in the research were availed under 7.2.1, 7.2.2 and 7.2.3. This chapter sets in motion the submissions that will be made in the next chapter which gives the epilogue of this research.

CHAPTER EIGHT
CONCLUSIONS

8.1 Introduction

This chapter discusses the commonalities and differences in the findings and relates them to the objectives, offers critical discussions, gives the limitations of the research, recommendations, and its contribution to knowledge, identifies areas of further research and draws a conclusion of the thesis. It would be incomplete not to let the reader know about the experiences of the researcher while conducting the research that culminated in the writing of this thesis. So, at the very end there is a section capturing the researcher's journey and the lessons learnt.

Having presented thus far the findings and discussions of this research, this chapter offers the grand finale of the researcher's exploratory journey titled, 'using the psychological contract to explore the experiences of migrant domiciliary care workers within London'. This eventful journey lasted four years. The formal leg of the journey commenced after admission into the research programme and followed various administrative processes. These included refining the research proposal, a literature review, supervisory and other progress reviews, all of which were instrumental towards building up the stamina required for the successful completion of the research journey.

In hindsight, the researcher recalls their trepidation when the decision to use the snowball sampling technique for accessing my research participants was made. It was clear in the researcher's mind that this was a hidden population but they were the subject of interest and there was no turning back. It was amazing to realize that in the end forty four migrant domiciliary care workers were recruited and interviewed. Having done that, the next milestone was to find out what the data collected was communicating. The data collected was colossal as is expected in qualitative research. It required a very painstaking iteration to make sense of it. As the researcher delved deeper and deeper there was greater clarity about the objectives. It is these discoveries that will be discussed in this chapter.

8.1.1 Key findings in relation to the research objectives

This thesis had three objectives which were satisfied through conducting a review of various literature and interviews with 44 migrant domiciliary care workers plying their occupation in London. The key findings are related to the three research objectives are presented in turn below.

8.1.2 To investigate the lived working experiences of migrant domiciliary care workers in their multi-foci employment

The participants in the interviews discussed their work experiences with their agency (or employing entity), their client, their co-workers and other persons they came into contact with as they performed their care giving roles including the multi-disciplinary team that was part of the care plan. It can thence be argued that the multi-foci employment relationship includes more parties than traditionally thought (a single and known employer, the employee and their trade union/some form of employee representation in the absence of a trade union). There are multiple 'employers' and a diminished role in reliance on trade unions for employee relations issues. Included also were their intra-sector job experiences where they used these to compare terms and conditions of service. For example, those who had served stints in residential care and nursing gave opinions about the opportunities for training available in this division of social care, unlike the current domiciliary care section that they are engaged in.

In their stories concerning other parties in their employment, only three participants reported being members of a union with the rest seeing no value for union membership. Most of the participants felt that they saw no role in which the union would be of use to them since their salaries were reviewed mainly through the annual National Minimum Wages Guidelines and for others the London Living Wage. Even in cases where employees felt they had experienced breach or violation in their psychological contract, most argued that they would or did not revert to the union for intervention, either because they were not unionized or that they could look for a job similar to the one lost, or not favourable to them without union help.

Concerning the inability by the research participants to offer conclusive answers about their employer this research finding was that the identity of the 'employer' does not prevent the formation of an employee's psychological contract. A psychological contract is formed with whichever party an employee believes they are in a promissory exchange relationship or transaction with. Hence, the psychological contract is held in the abstract, in the employee's mind with several people simultaneously with or without their knowledge. The stories of most of the research participants touched on the identity of their employer. Some said that they were unsure as to who (Individual/organization) was their employer, while others were clear. The labels Agency, Local Government, Individual budget holder, Client's family, Client (for live in carers) were applied to describe their employer. In some cases some of the participants mentioned that the care plan directed their activities and chose to not assign anyone/any organization the role of their employer. This ambiguity can be explained by the nature of the employment structure in independent domiciliary care provision following the changes in social care provision in England. Details about these changes and their impact were comprehensively discussed in chapter three. There have been debates about the identity of the person (s) or organizational agency with whom the employee in an organization holds the psychological contract. Even where the employer is known, this has not been clarified. The organization is an entity, not human, hence even in anthropomorphizing it must be remembered that only humans and other humans can hold a psychological contract.

8.1.3 To examine the tensions within domiciliary care work

Contrary to claims by Fleisschmann and Donnkers (2010) that citizenship status does not impact on migrants labour outcomes this research determined that the status of migrants to a large extent pre-determined their labour market experiences and the jobs they were likely to hold during their 'migrant' status phase. A claim by Cook et al., 2011 that European Union migrants' transverse the labour market if desirable pay and work conditions were offered was however confirmed. This is particularly true of the new entrants in the labour market who were job prospecting while awaiting accreditation of their work documents in which case they could do any avail job in the hope of getting a better one later. Migrants of non-European Union immigration status were however not found to do so. Theirs was inter sector movements for any available shifts perhaps due to the complexity of the waiting time while getting clearance on good conduct from the

Disclosure and Barring Service (DBS) One can only use a DBS certificate in a new employment if it is less than three months old, it requires payment for a new application and this was found to be an extra financial burden to the carers and so they decided to settle on the jobs they were holding. This confirms that each migrant has their own experience and reacts according to what they weigh to be profitable in the circumstances.

It was established, in parallel to McDowell (2009), that 'whiteness' was a relational concept rather than a singular unvarying category because of its constructing being premised on the way it positions others at its borders and that there are degrees of whiteness based on the stories of Eastern European similar to observations by Roediger (2002). Their physical resemblance to the indigenous white UK population did not camouflage their 'whiteness' and they were treated differently, especially when they opened their mouths in conversation and their accented English surfaced. The assertion by Hancock (2007) that experiences of racism are inherently complex and part of intersecting factors was proven through participants discussions where their stories intersected between ethnic, cultural, language and class related pigeonholing. The researcher concurs with Guest and Conway (2002) and Rousseau and Schalk (2003) in their recommendation that national culture and organizational culture should be seen in juxtaposition when building the analytical framework for analysing employment relations and the psychological contract. This may be helpful in aiding parties in the social care sector (employer, employees and clients) to form of an understanding of the heterogeneity of the players in the sector and reduce tensions.

The challenges and adjustments that domiciliary care workers go through in their daily work life and their frustrations about inability to change some of the obvious poor quality services they provided to their clients corresponds with an argument by Atkinson and Crozier (2016) that no one sets out to provide bad care but you are dragged into the gutter. A case in point is the confirmation from the stories of research participants of the presence of care calls lasting 15 minutes congruent with the findings of a study by UNISON (2016) where 74% of local councils in England were reported to be commissioning visits lasting 15 minutes or less. Care work shifts follow the hourglass pattern where there are high demands in the morning and in the evenings over the whole week leaving little or no time for rest and recuperation for the staff were they to

take on the available shifts corroborating the findings of a research by Rubery, Grimshaw and Ugarte (2015).

The duty rota was found to be very demanding as it involved calculative operationalization both from the side of the domiciliary care worker and their employer given that adaptability is considered by employers as very important comparable to Pulakos, Arad, Donovan and Plamondon (2000). So pivotal was the rota that the repetitive descriptions of its use and how they felt subjugated to it affirmed the claims by Bolton and Wibbereley (2013) that it was more than an administrative tool and a representation of the political economy of this type of care work which often times does not allow for the unpredictable client demands. The care plan, through which care is converted into a tradeable commodity and where there is a sustained need to reconcile the tensions inherent in a care plan which offers no time to care, was a source of discomfort and anxiety among the research participants, confirming the arguments of Bolton and Wibbereley (2013).

Time affects pay, leave, rest and recuperation, work life balance and the relationships between the Carer, the client (and the client's family where applicable), the care and their co-workers and that between the carer and their primary employer. Where time impedes the duty execution of the domiciliary carer then this can be interpreted as indicating the formation or presence of a transactional contract. For example when a Carer is late because of the design of the rota, the client will complain, the carer will be angry at the complaining client, yet the client is asking for what they have paid for and at the same time the agency is aware of the constraints the carer is having to undergo to meet the travel, but not doing anything to alter the timings. This carer needs the shifts even though they are so close in time due to the low wages they receive. At the end of it the carer will be accustomed to complaints from the client about lateness or hurriedly perform earlier tasks to leave time for travel to the next as described by Alayna in her story.

The stories of research participants alluded that the work can be stressful, that there can be a lack of respect and recognition and that there are problems of communication similar to Burke (2011); (Mittal et al., 2009); (Tadd, 2005) and Kemper et al., (2008). A postulation by Likupe (2006) that communication problems suffuse work place relationships with tensions was

replicated. These problems cut across carers, co-workers, their clients, client family members too. The reports of high job satisfaction amongst domiciliary care workers by Robinson and Banks (2005) and another by Skills for Care (2013) were contradicted as there was little evidence of 'job satisfaction' in their narratives. For example, if job satisfaction were the object of the research and the participants were asked if they were satisfied with their job, some would probably have said they were especially if they had cordial relations with their clients and co-workers. Put differently if questions about pay levels were explicitly asked, then there may have been a less positive response.

The stories of a good number of migrant domiciliary care workers in this research confirmed an argument by Anderson (2007) that employers frequently construct racial stereotypes of carers based on their nationalities. Cultural differences have an impact on and shape most of the tensions within the domiciliary care provision.

8.1.4 To use the work experiences of migrant domiciliary care workers to scrutinize their psychological contract

In recapping what was discussed in chapter 7, there is evidence of transactional Psychological Contracts but none on relational ones. There is also evidence of transitional Psychological Contracts although with some divergence from how these are normally defined. The balanced contract did not appear to be held by any of the research participants.

The reasons that compelled the domiciliary care workers into migrating played a crucial role initially as the migrant decides to commence domiciliary work. The migrant status at entry and even further down the line also impact on their continued working as domiciliary as shown in the findings. In almost all the respondent cases some form of referral brought them into the awareness that such a job existed and was readily available. These networks continue to play a crucial role in the lives of individual migrant workers in their chequered job roles in and out of the low employment sector not in a job hopping sense but for subsistence during periods of unstable employment. This finding negates that of Ow Yong and Manthorpe (2016) who placed a six month timeline within which the migrant workers made use of their in-country social networks.

There was prevalence for the formation and maintenance of a transitional contract among those migrant domiciliary care workers who were on student's visas, those who had small children under full day school going age and the new arrivals from Eastern European countries. Those who were on other categories of visa that could over time transform into indefinite leave to remain in the United Kingdom portrayed tendencies of operating transitional psychological contracts too. These interviewees group seemed the most contented with undertaking care work. They laboured each day with hope and anticipation that as the days moved by they were getting nearer to the day when their immigration status will change and then they can leave domiciliary care work to go into jobs leading to the careers of their choice.

The older employees who had worked for local authorities in the past and who find themselves in the new care provider regimes have a transitional contract. Some gave stories of hoping to find their way back into employment by local authorities while others were in denial that the local authority was not still their employer despite them presently working within the independent providers hire. The pressures and constraints around time do not permit the flourishing of a relational contract as a relational contract requires time to nurture. Where there are contestations about time and squabbles between the carer and the client a transaction contract is in place with the client doing what they can within the time they are at the client's and the client being very precise about the time the carer comes in and leaves. In instances where a carer is covering a shift for another absent carer, then the psychological contract held during such exchanges is both transactional and transitional; transactional due to its short and definite time span and transitional since it is spontaneous and temporary.

Even for seemingly low skilled jobs, as domiciliary care is erroneously deemed to be, the job holder may view training as an expectation, for which the employer is supposed to play their role not only for ensuring that the employee is equipped with the right training, but that it is timely, up to date and leads to a clear career development path. A poorly trained or non-trained employee within domiciliary care is a danger to both themselves and the client. The job entails some hazards like health and safety issues, sometimes communicable diseases, dealing with mental health clients and other forms of aggression, lone working and some para medical work that the domiciliary carer is expected to perform or have an awareness about. Though training

was not established as standing alone or as part of the psychological contract, owing to it being an expectation and not promissory from the stories of the interviewees and the operational definition of what the psychological contract entails. The participants' view about the type, consistency and level of training offered precluded the formation of balanced and relational contracts. The disquiet about the training offered if investigated further may suggest a breach of the employee's psychological contract but well within their threshold levels. Those holding transitional psychological contracts appeared less bothered about training as they were intent on moving on from their temporary engagements and may not utilize any on the job trainings in their new engagements.

When perceived prejudice from clients is taking place a relational contract cannot develop. More so, where the work demands inconvenience the worker, the other type of psychological contract that can be identified is a transitional one. This is one where the worker sees the job as meeting their short term or immediate needs, performing it to their best even if they have to suffer inconvenience but waiting for the opportune moment to leave such employment. If the transitional contract is looked at similar to the definitions based on the organizational case studies whose findings Rousseau (1995) and Jepson and Rodwell (2012) then, the changes in the social care sector which most of the interviewees have alluded to constitute what can be inferred to mean break down of an existing or earlier contract.

An evidence of the transactional nature of the relationship between agency staff and their employer was noted in their descriptions of how due to time constraints they drop in their time sheets at the office mailbox at the end of their work week. They described that if the time sheet was not received in the office by a specific time they would not be paid for that period. Given that the pay is low and that the carer's budget to the last penny the fear of missing a payment makes them use this mail posting system. The rampant use of texting to notify the agency about their availability for work weekly or monthly epitomizes a transactional contract. The stories of most of the research participants touched on the identity of their employer. Some said that they were unsure as to who (individual/organization) was their employer, while others were clear. The labels Agency, Local Government, Individual budget holder, Client's family, Client (for live in carers) were applied to describe their employer. In some cases some of the participants

206

mentioned that the care plan directed their activities and chose to not assign anyone/any organization the role of their employer. This ambiguity can be explained by the nature of the employment structure in independent domiciliary care provision following the changes in social care provision in England. Details about these changes and their impact were comprehensively discussed in chapters three. There have been debates about the identity of the person (s) or organizational agency with whom the employee in an organization holds the psychological contract. Even where the employer is known, this has not been clarified. The organization is an entity not a human hence even in anthropomorphizing we must remember that only humans and other humans can hold a psychological contract.

The commodification of care and domiciliary care as a labour process with tight time schedules hinders the development of relational and balanced psychological contracts. The work structure, patterns, rota and even the contracting of care hours dictates the formation of either a transactional or transitional psychological contract. The prototype of the relational contract epitomized by Rousseau (1995) was not identified in the stories of any research participants. This may be due to the reason that Rousseau's study was conducted within specific organizations while this study involved individual participants representing themselves and not their organizations or from a particular organization. It is noteworthy that the cadre of staff interviewed differed. Rousseau's participants were management trainees and employees in a research centre who can be considered in professional jobs, unlike this study's interviewees. Rousseau's participants were homogeneous by virtue of being in the employment within the same organization and holding relatively similar qualifications, yet this research participants were not only drawn from different work settings but were also migrants of diverse ethnic, cultural and socialization orientations and educational attainments.

The unequal power relations between the migrant domiciliary care worker with their employing body; with their client/client's family and that with other social care partners hinders the development of a fully-fledged relational psychological contract. The live-in carers interviewed though seemingly having more interaction with their clients' by virtue of the almost daily physical proximity with their employer through residence in their client's homes, reported feeling exploited.

The absence of training for employability and the shaky performance management impede the any creation of a relational or balanced psychological contract with regards to this group of participants. In conclusion the study did not establish the lived working life experiences of any migrant domiciliary care worker as suggesting they has a balanced psychological contract. The care-work relationship is swerved by both power and affection or emotion on both sides of the relationship (Bodi, 2008) hence this finding.

Interestingly relations with co-workers (referred to as double-ups in domiciliary care language) were constantly mentioned in the stories of almost all the research participants. Using the definition of a psychological contract adopted for use in this research that:

> '*the psychological contract is 'an individual's belief in mutual obligations between that person and another party such as an employer (either firm or another person) a belief being predicated on the perception that a promise has been made (for example employment or career opportunities) and a consideration offered in exchange, binding the parties to some set of reciprocal obligations' (Rousseau and Tijoriwala, 1998, p.697; Jepson and Rodwell, 2012)*

This research concluded that the relations though about actions or inactions of the co-workers did not constitute the migrant domiciliary care workers telling the stories to be in a psychological contract with their co-workers. This was more about their expectations of their co-workers in ensuring duty performance or equity in sharing out the existing time shifts. The employees and co-workers were paired up by the employing entities and had not made promises to each other. It is the researcher's conclusion that the expectations the domiciliary care workers their relationship with held of their co-workers are not psychological contracts.

Finally, when thinking about domiciliary care work, the domestic aspects of the job are given peripheral consideration. However the domestic work that is required for the comfort of the client as part of their wellbeing sometimes falls within the responsibility of the domiciliary carer whether by job design (where cleaning is included in the care plan) or by default where the altruistic nature of the care worker is put to test due to the unhygienic conditions they find their clients.

8.2 Recommendations

One of the motivations for undertaking this research was the researcher's wish to give migrant domiciliary care workers an opportunity to give their views about their job. Having convincingly done this, it would be unbalanced not to offer suggestions on how some of the identified problems may be addressed.

Firstly, social care should be given the due importance it requires within the UK. One issue that needs addressing is setting aside enough money in the allocated budgets so that commissioning authorities offer realistic service rates. This may perhaps lead to the service providers particularly those in the independent sector finding this noble service profitable and passing on the gains to those they employ. This can lead to improvement in the working conditions which may lead to the provision of good quality services.

Secondly, unions can explore innovative ways through which they can recruit migrant domiciliary care workers. This population needs some representation but may be unaware of the options available and how to access union membership even though most have flexible or zero hour contracts.

Thirdly, there ought to be emphasis on cultural awareness not only in the social care sector but generally at the national level where definite programmes are put in place to involve all stakeholders in the social care sector and particularly the clients as they are part of the problem and also because London (and the UK) is multi-cultural and that will not change. Using politically correct language to sugar-coat some opinions that may border on unacceptable 'othering' does not change the mentality of the perpetrators' and the recipients of such acts. The 'migrant problem' needs to be approached with sobriety. Initiatives may include employee training, campaigns to foster diversity beginning at the most basic levels, then cascading this into the wider society.

Fourthly, migrants into the UK also have the responsibility for their acculturation in the host country to avoid some of the hardships they experience in their job roles. They can however retain their unique cultural markers of language, food and customs in the domestic sphere but repect the host nation culture.

Fifthly, there needs to be better training and standardization within the trainings offered and recognized within the social care sector. Though the Care Bill 2015 has attempted to try and do so, more needs to be done. Given that domiciliary care workers work from client's houses often times the responsible authorities may not get to grip with the type of training provided. The Care Quality Commission can deal with this better through impromptu visits to registered domiciliary care providers and also making it mandatory for all providers to register so that it would be easy to provide the Care Quality Commission's inspection and quality oversight mandate.

Sixthly, the issue of prevalent use of zero hours should be addressed. A clear legal interpretation should be provided to make it impossible for some employers to blatantly ignore, misinterpret or selectively apply the legal provisions. It would also be helpful for employers to apply Best Practice in application of the legal requirements of the zero hour contracts unlike the current Best Practice which leaves employees on such contracts at the mercy of the favourable interpretation and application by the employer.

Seventh, training should be consistent across the board as it impacts on the quality of care being provided. Certifications can also assist in upward job mobility or even moving intra sector. Training should not be for superficial compliance, it should be consistent and service led irrespective of whether the domiciliary care employer is a large or medium employer. Perhaps owing to the importance of training for the effective delivery of service in the sector, funds may be availed as well as some exemptions be offered to assist carers who may be unable to access public funded trainings by virtue of their immigration statuses (for example those on student visas).

In conclusion, modest recommendations can be taken up or improved on to improve the provision of social care (domiciliary care included). While it is acknowledged that most of the recommendations require that the government and employers invest more money at a time when they seem reluctant and bearing in mind that the clients are often unable to afford any extra expenses towards their care, the concerted efforts of all stakeholders and others of good will perhaps make a difference.

8.3 Research Contributions

Earlier studies combined workers in the social services sector including nurses and therapists and those in residential care with only a brief mention of those in domiciliary care. That this research is specifically on domiciliary care workers has provided recent sector specific information to the growing body of literature. Whereas other studies considered migrants from a singular ethnic background (see McGregor, 2007; Ow Yong and Manthorpe, 2016), this research interviewed migrants from a wide variety of ethnic backgrounds, thereby making a contribution to the existing knowledge on the heterogeneous migrant domiciliary care workers experiences.

This research establishes that the migrant domiciliary care workers hold a psychological contractwith each 'party' to the employment relationship that they see as relevant, whether this be the company (or companies) that employ them, the clients. With the employer that is based at the registered company office, most maintain a strictly transactional contract in the sense that they comply with the rules and regulations as best as they can in turn for the wages as agreed (mostly the national minimum wage). With the client, it is situational ranging from transactional to transitional. Therefore it is concluded that it is possible to hold more than one psychological contract at a time and with more than one employment party and that this is context dependent. This research offers contemporary knowledge on these issues that have been in the contingent workers psychological contract discourse.

Though this research was conducted, the analysis undertaken and the conclusions drawn at the opportune time when the Brexit referendum was being held and outcomes on-going. The resultant debates on the outcome of the vote have highlighted migration as an issue of deep concern in contemporary United Kingdom. The role and large presence of migrants in the UK

domiciliary and by extension social care services has been well highlighted in their stories. It has been demonstrated that even though the migrant domiciliary care workers are heterogeneous, the idiosyncrasy of the psychological contracts was established even when describing similar migration trajectories and work experiences.

This research has offered an insight into the experiences and mental motions that domiciliary care workers go through in a candid way which may interest other researchers to investigate other employment sectors that have many migrant workers. The choice of the research methods of using narratives and Interpretative Phenomenological Analysis and Hermeneutic Phenomenology in this research is distinct. Although the conventional way of undertaking Interpretative Phenomenological Analysis driven studies uses small samples, the decision to use a large sample and yet meet the Interpretative Phenomenological Analysis quality requirements may set a precedent for other researchers who may explore a similar route and this could eventually lead to a methodological contribution.

Finally, this research has provided rich descriptions of the lived experiences of migrant domiciliary care workers within London. Their stories can provide food for thought among stakeholders in the care provision sector, information that may lead to a review on some of the existing policies. Parties that may find these findings useful include the Social Care Services Departments, the Local Authorities, Home Care Association, Trade Unions, Human Resource and Organizational Development Specialists.

8.4 Limitations of the research and Future Research

Firstly, though migrant domiciliary care workers can be found in almost all parts of the United Kingdom this study was conducted in London. Had the geographical scope covered the whole country then the findings would have been more representative. The findings are attributed to the experiences of migrant domiciliary care workers in London. One of the unwritten aims of this study was to whet the appetites of scholars who may then take on the challenge to enquire by conducting further research in this area. Such research may unearth new findings or they may replicate these findings in other places in the United Kingdom and particularly in places where

the number of migrant domiciliary care workers is lower. This would be a welcome furtherance of this study's demonstrable contribution to knowledge thus far.

Asking and expecting the research participants to discuss and story their lived work experience meant them trying to recall events as they had happened. None of the participants had previously told the story of their lived work experiences for a research purpose. The narrative approach is an underdeveloped area. Future researchers can take it up and improve on it as it has shown itself to be a fruitulmethod of studying perceptions and experiences.

During the period under which this study was taking place, there were few studies in United Kingdom from which to obtain literature. This led to the researcher having to borrow from studies conducted among migrant carers in other countries such as Ireland, Canada and the United States. The researcher also had to use literature from studies from nursing, residential setting and on migrants in industries that were unrelated to the subject matter- the psychological contract and work experiences. Taking an example of a migrant female domiciliary worker, who suffers due to her gender, her marital status, her race/ethnicity and her lowly social status ascribed from the job she is undertaking, this research has provided the definitive work using the psychological contract, but other researchers may use a different lens to interrogate this.

This research did not attempt to measure the psychological contract of the migrant domiciliary care workers using measures similar to those in the psychological contract measurement inventory by Rousseau (2000) as the participants were not drawn from one organization but from a host of employments within the care industry. Maybe further research can measure the psychological contract of migrant domiciliary care workers using participants from an organizational setting. This was a self- funded research so there was limitation on the size. This being an exploratory research did not intend to feign generalizability. A proposal is that in future research, building up from where this research has paused, a longitudinal and large scale quantitative research can be undertaken as this would allow for greater generalizability and build on the insights provided by this research.

8.5 Reflection on the research journey

In hindsight I can confirm that, though then unknown to me then, my research journey began during my tenure as a domiciliary care worker in the United Kingdom whilst I was undertaking my Master's degree programme. As stated in earlier chapters within the thesis, I left Kenya as a highly qualified and experienced senior human resources practitioner having worked nationally, regionally and internationally. In one of my employments, I served within the non-governmental sector (charitable organization) and experienced first- hand the deprivation and hopelessness people go through during and after incidents of natural disasters (floods, famine and drought), political unrest (coups and dictatorial regimes leading to people becoming refugees), religious intolerance (terrorist acts and other forms). This happened during emergency relief and developmental phases as the charitable organization I was employed in tried to help the victims and survivors.

So, after failing to get a part time job in the UK similar to my earlier professional one, being a migrant I settled for the only available job where my twenty hours of work per week would be accommodated. I ensured that I complied with the stipulated visa restrictions during my stay. As a self-sponsored internationally assessed tuition paying student, the money I earned supplemented my accommodation and travel expenses. The domiciliary care job was new to me as I had never done this before. In my home country, persons with disabilities are catered for within their families and it is unusual to engage the services of a stranger (non-relative) to offer the required care services. After my initial reservations and the cultural adjustments in the new country and domiciliary care work, I found myself settling in well and enjoying the job. I encountered both hardships and fulfilling experiences with both clients and co-workers some similar to those contained in the stories of my research participants.

I completed my studies and went back to my human resource management job. When I decided to undertake a PhD, I felt it was imperative that I pick a topic that I had interest in and one in which I could also draw from my professional experience. It was clear in my mind that migrant domiciliary care work fitted into my research aims. Next was to write an acceptable research proposal that would attract supervisor interest. I finally obtained admission at the University of East London. I embarked on the research journey in October 2013. I had to change quite a

number of things in my initial research proposal including the proposed title, having done that I commenced an active literature review, the all-important question on the research methodology, participant sample size and how to analyse and discuss the findings. The purposive snowball sampling method was selected for obtaining the research participants and a simple research question asked to elicit participant views about their work experiences. The sample population was from different employment organizations and represented a maximum variation of the diversity within the migrant domiciliary care workers being interviewed.

This process led to 44 people being interviewed. Interpretative Phenomenological Analysis and Hermeneutic Phenomenology were adopted for data analysis. An unexpected challenge was the realization that most Interpretative Phenomenological Analysis studies conventionally use small samples. Given that the motivation of this research was to give voice to the migrant domiciliary care workers and that unlike my expectations that it would be hard to obtain research interviewees the participants willingness to not only being included in the research but to also referring others was unexpected but welcome. It was observed that this group individually indicated that none of them had participated in a research before and no one had asked them about their work, so they were quite enthusiastic in taking part in the research. Commenting on the point at which saturation is likely to be reached, one unique observation as I listened to each as I undertook transcription after each interview, I noticed that new information had been supplied egging me on to get a larger sample. One of the requirements in Interpretative Phenomenological Analysis led analysis is that rich and thick descriptions be provided. The use of verbatim excerpts and hermeneutics allowed me to meet this requirement. As indicated within the methodology chapter, in this particular research the use of a large sample was justified. Lastly, after satisfying all the university PhD research administrative processes, I was allowed to get to the write-up stage and after successful completion was the viva voce defense of my PhD thesis.

Lessons learnt

Undertaking a PhD research degree is a monumental and daunting task that requires thorough preparation and planning financially, physically, psychologically (mentally and emotionally) and in terms of time management for its completion within the required academic time. It is both exciting and challenging for a researcher who has moved to the country from which they are undertaking their research. Like all students, it does not matter the age of the researcher and that this is at post graduate level research degree, the emotions through which a student goes through concerning meeting academic deadlines and the apprehension about the quality of work and assessment are somewhat similar.

There were unexpected turns and twists in the journey sometimes leading to my wanting to throw in the towel, feeling like deferring the studies or in frustration shedding tears. This was especially when the corrections seemed insurmountable and when I thought I was running out of time. Being a non-native English speaker, the English language being my third language, despite having used it as the medium of communication and assessment in all my academic studies, I still made some grammatical mistakes that a native speaker would point out easily. Having two native English speaker supervisors proved very helpful as they assisted me on this.

I learnt that the harmonious relationship between a researcher and their supervisor is of utmost importance. Whilst the researcher insights which the supervisor can give to the researcher given their vast experience and expertise as well as research interest in the topic their charge is researching on. Supervisor-suggested readings are invaluable as was in my case. Unlike other educational programmes, this type of research requires the research student to take ownership of their project. The supervisors have a somewhat psychological contract with their student as there are obligations that each of the parties in this relationship has to meet. An example is that the supervisor holds supervisory meetings with the student. I would at times be overwhelmed and hibernate, but thankfully my supervisors would 'fish' me out and through their encouragement guide be back on track.

PhD studies can be so demanding that the student spends most of their time in the library or on research related stuff. This may appear like they are anti-social or reserved. It can be lonely but networking with other researchers such as attending conferences, presenting your work, even if it is still in progress, for peer review and feedback in research forums can alleviate this. From my experience presenting my work in working sessions in conferences gave me confidence and also allowed me to benefit from other researches particularly on qualitative research methodology. The task executed, though ably, was onerous and took everything out of and in me. There was also an unclear boundary as to how shallow or deep one can go in using well-researched concepts from the psychology field. However, I have no misgivings on the approach to the study taken, given that I have given the migrant domiciliary care workers a voice, as I set out to do.

Finally, after a long, measured and winding research journey into a relatively under-researched terrain – that of the living worked life experiences of migrant domiciliary care workers in London, three stories have been told. The first is the researcher's account about the motivation for undertaking the research including the choice of methodology. The next, the main story, being the one of the lived work experiences of the forty four migrant domiciliary care workers that took part in this research, told through an interpretation of their descriptions of their day to day experiences at their workplace, with their clients, their colleagues (where applicable) and other players in the social care service provisions. The third story the final one being the researcher's reflective journey during the inception, development and eventual write up of this thesis.

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APPENDICES

Appendix I: Ethics Approval

22 April 2015

Dear Cathlynn

Project Title:	Using the psychological contract to explore the experiences of domiciliary migrant care workers within London boroughs
Researcher(s):	Cathlynn D'silva
Principal Investigator:	Dr John Chandler
Reference Number:	UREC_1415_71

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered at the meeting on **Wednesday 18th March 2015**.

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
Mutually agreed locations in London	Dr John Chandler

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
UREC application form	2.0	08 April 2015
Participant information sheet	4.0	22 April 2015
Risk Assessment	1.0	04 March 2015
Consent form	3.0	21 April 2015

| Narrative interview guide | 1.0 | 04 March 2015 |

Approval is given on the understanding that the UEL Code of Good Practice in Research is adhered to.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Rosalind Eccles
University Research Ethics Committee (UREC)
UREC Servicing Officer
Email: researchethics@uel.ac.uk

Appendix II: Participant Information Form

<u>**University of East London**</u>
Royal Docks Business School
Docklands Campus
University Way
London
E16 2RD

University Research Ethics Committee
If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:

Catherine Fieulleteau, Ethics Integrity Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: <u>researchethics@uel.ac.uk</u>).

The Principal Investigator(s)
Dr. John Chandler
University of East London
Royal Docks Business School
Docklands Campus
University Way
London
E16 2RD[Telephone/fax/email (including an out-of-hours number)]

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title
'Using the Psychological Contract to explore the experiences of Migrant Domiciliary Care Workers within London'

Project Description
The aim of this research is to investigate the lived work experiences of the Migrant Care Worker and their employer (the Client, the Client's family and the Employment Agency)

As a participant in this research you will be interviewed and asked questions around your experiences as a migrant domiciliary (home) care worker in your work relationship with the various employment parties that you interact with in your day to day work. The interview will be audio- recorded through use of a tape recording device with the researcher also taking notes as necessary.

In participating in this research it is not anticipated that you will be put into any hazard or risk. You are however free to withdraw your participation at any stage of the research should you so wish

Confidentiality of the Data

Your identity will be protected and the data analysis and reporting will be anonymized and coded. Data will be stored electronically in a password protected server and manually in a secure storage. Upon completion of the research data will within six months undergo secure disposal.

Location

The research will be conducted in specified locations convenient, secure and accessible as agreed between the researcher and the participants. These locations will be within London.

Remuneration
This is a self funded research for academic purposes and will therefore attract no remuneration.

Withdrawal from participation in the research
You are not obliged to take part in this study, and are free to withdraw at any time during the research. Should you choose to withdraw from the programme you may do by contacting the principal investigator. This will be without disadvantage to yourself and you are not obligated   to give a reason for your decision.

Appendix III: Participant Consent Form

UNIVERSITY OF EAST LONDON

Consent to Participate in an Experimental Programme Involving the Use of Human Participants.

'Using the Psychological Contract to explore the experiences of Migrant Domiciliary Care Workers within London'

I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the experimental programme has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name: ………………………………………………

Participant's Signature: …………………………………………………

Investigator's Name: CATHLYNN D'SILVA

Investigator's Signature: …………………………

Date: ………………………….

Appendix IV: The Interview Question

'Could you kindly tell me the story of how you found yourself working as a domiciliary care worker in the United Kingdom? Give me specific examples of your day to day working experiences and everything else that you may deem necessary to help me understand your role'.

Appendix V: Coding and Thematic Analysis

THE INITIAL INDUCTIVE DATA ANALYSIS OF THE NARRATIVES

Recurring words	Sub themes	Final Theme
Language, Writing, Reading, Non-verbal , Body language, English, Gestures, Write it down, Documentation, Speaking, Body map, Incident book, handover, Greet, Feedback	Interactions at work Document management Communication hitches Communication impediments	Challenges with communication
Culture, Values, Beliefs, Ethos, Customs, Ethics, Traditions, Religion, Different, Conflicting, Incompatible Race, Racist, Racial, Stereotype, Ethnic, Skin colour, Groups, Grouping, Discrimination, Different treatment, Indifference, Profiling, Abusive, Insulting, Bias, Black, White, Asian	Xenophobia Chauvinism Othering Identification	Prejudice
Poor pay, Low pay, Travelling, No travelling allowance, Limited time, Hurried time, Transport, Covering, No leave, hours of work, No compensation, Zero hours, Zero hour contract ,Work life balance, Holiday, Rest, Recuperation, Exhaustion, Care-plan, Duty rota, Time sheet, Clock in, Clock-out, Double-ups, Lone working	Working terms and conditions Leave issues Zero hour contracts Work life balance Fragmented time Service provision-related–time Carer related - time	Time Constraints
Fear over safety, safeguarding, DBS Check, work place violence, fear of assault, criminal record, Police caution Biting, Spitting, Punching, Verbal abuse, Pushing, Bending, Back pain, Body aches, Hoisting, Manual handling	Carer safety Client safety Dangerous work places Occupational Health and Safety concerns	Safety Concerns
Basic training, Job related, Training, NVQ, Shadowing, Appraisal, Promotion, Development, Career, Progress, Profession, De-skilling, irrelevant. No time, Unpaid	Inadequate training Lack of progression opportunities Accreditation challenges	Disquiet about the training offered

Issues identified across the themes	
Issue	**Description**
Trade Union membership	Not union member, no need for union, not useful, not eligible, not approached to join, unbothered, unnecessary, unsure
Gender relations	Cordial, guarded, women have an upper hand, men suited for manual the dexterity required, women for more 'feminine' roles, highly gendered, no tokenism for males
Multiple portrayals of Employers	Client, Agency, Client's Family, Local Authority. Manager, Supervisor
Perceptions about the role	Stressful, Demeaning, Difficult, Challenging, Straining, Dangerous, Unsafe, Persevere, low status, Degrading, Not easy, Misunderstood

Appendix VI: Deductive Analysis of the Themes in Relation to the Psychological Contract

Themes	Description	Inferred Psychological Contract
Challenges with communication	Misinformation, Misunderstandings, Complications, Difficulties, Poor	Transactional Transitional
Prejudice	Feel demeaned, deflated, maltreated, labeled, misunderstood	Transactional Transitional
Time Constraints	Inadequate, hurried, Rushed, fragmented, a balancing act	Transactional Transitional
Disquiet about the training offered	Only for job performance, not adequate, One-off, Infrequent, certificates not transferable to another employer	Transactional Transitional
Other issues Analysis		
Motivation for engaging in domiciliary care	Only available job, survival, sustenance, not career, not profession, temporary work	Transactional Transitional
Expressions on feelings on breach or violation	Stressed, Fearful, Apathy, Apprehension, Dissatisfaction, demotivated, Acceptance of fate, No recourse	Transactional Transitional