CHAPTER 8 – Innovation, Job Quality and Employment Outcomes in Care: Evidence from Hungary, the Netherlands and the UK

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1 Introduction 332
1.1 National contexts for care for the elderly 332
1.2 Generic factors influencing the development of the care sector across countries 338
2 Case studies, key features of the care sector and main findings 340
2.1 Introduction to the case studies 340
2.2 Case study evidence on key features of employment and job quality 342
2.3 Showcasing innovative practices from the case studies 345
3 Inter-relationships between innovation, job quality and employment 369
3.1 Impact of innovations on job quality 369
4 Conclusions 373
5 References 375
6 List of Case Study Reports and Industry Profiles 376
7 Annex – Summaries of Case Studies 377

1 Introduction

This chapter is concerned with exploration and analysis of the inter-relationships between innovation, job quality and employment in the care sector. It draws on empirical case study research of care organisations/companies from Hungary, the Netherlands and the UK.

The care sector is different from, but related to, the health sector. A key distinction in the care sector is between residential care (where an individual is cared for in a residential care home/nursing home where care staff are employed on site) and homecare/domiciliary care (where individuals receive care in their own homes by carers and other workers coming to visit them). The focus here is on the latter type of care and on a particular element of the care sector: that concerning caring for elderly people in their own homes undertaken by paid carers. Unpaid care provided by friends and family members to elderly people in their own homes is important in volume and socio-economic terms but is excluded here from direct consideration, albeit it is of indirect importance given that increasing reliance on informal care changes the role of some paid carers to include actively involving informal carers in care provision for clients.

This chapter is divided into four sections. This first introductory section provides an overview of how the care sector is structured and funded in Hungary, the Netherlands and the UK, before identifying common generic factors influencing the development of the care sector across countries. The second section introduces the empirical case studies of care organisations, presents case study evidence on key features of employment and job quality and their implications for social inclusions, before showcasing organisational and technological innovations from the case studies. The third section analyses inter-relationships between innovation, job quality and employment by synthesizing evidence across the case studies. Overarching conclusions are presented in the fourth section.

To understand the inter-relationships between innovation, job quality and employment outcomes in the care sector it is necessary to appreciate the context in which it operates. This section sets out the national contexts for the care sector in Hungary, the Netherlands and the UK in turn, and then identifies common generic factors that influence the development of, and challenges and opportunities facing, the care sector across the case study countries to greater or lesser extents.

1.1 National contexts for care for the elderly

There are some variations between the three case study countries in how the care system is structured, regulated and financed, and how it relates to the health system. It is important to understand these different parameters as they shape opportunities and set constraints for innovation.

In ***Hungary*** social services for older people are regulated by Act III of 1993 on Social Administration and Social Services (*SzT*). This Act defines the various forms and structure of care as well as the conditions of entitlement including a guarantee for access (Tróbert and Széman, 2016).

As is the case in England (see below), the social service system in Hungary operates independently of the health sector. Following a change in the political system, one of the basic functions of the 1993 Act was to define the responsibility of the Hungarian state, including ensuring the conditions for social care (beyond the responsibility of individuals, their families and local communities) is the task of the central organs of the Hungarian state and the local government and that the state and local governments are responsible for providing personal care for the socially needy (Udvari, 2013). An important distinction is made between *basic social services* (such as village and scattered farm caretaker service, meals, home help with alarm

system and day care) and *specialised services* (such as institutions providing temporary placement including care homes for the aged, nursing and care homes).

Home help service and institutions providing long-term care play important roles in elder care in Hungary (Tróbert and Széman, 2016). The basic pillar of elder care in Hungary is home help. In 2000, 40,292 people received home help whereas in 2014 this figure had increased to 132,985 (KSH, 2016). Despite a more than three-fold increase, the service has not kept pace with the growing number of people receiving care, where the number of care receivers per care worker increased from 4.7 in 2000 to 9.5 by 2013 (KSH, 2016). Home help with an alarm system is a supplement to home help, where the aim is to allow older people to remain living in their own home, but the state provides assistance in times of crisis (Tróbert and Széman, 2016).

Residential institutions are the second pillar of the Hungarian system of elder care. In 2006, 84,133 persons lived in residential institutions; the number having risen to 90,311 by 2014 (KSH, 2016). These residential institutions are not the primary focus here.

Financial social care in Hungary remains the task of the state (local government). However, churches and the private sector are also present among the providers and institutions. Out of the 55,426 people receiving residential care in 2014, just over two-fifths lived in homes maintained by local governments and other state bodies, close to 18 percent lived in institutions owned by churches, 10 percent lived in institutions owned by not-for-profit associations, just over 6 percent lived in foundation-operated institutions and 4 percent lived in association-operated institutions. The remainder was spread between homes operated by public foundations and institutions operated by joint ventures (KSH, 2016).

In theory, individual services are interlinked however there are gaps in provision whereby it is difficult to achieve a smooth transition between the different forms of service (Tróbert and Széman, 2016). On the basis of Regulation No. 36/2007 [*SZMM on the detailed rules for examining and certifying the need for care and social neediness on the basis of health status*], in 2008 the assessment of care need was introduced as a condition for access to services. A five-point assessment scale was introduced where the individual's score is used to determine eligibility to care need (expressed in terms of the number of hours of care the individual is entitled to be based on their self-care capability). If the need for care does not exceed four hours per day, an application can be made for home care. If the need of care exceeds four hours per day, the individual can be placed in a residential institution. So in this way, the two elements are interconnected. In practice, however, the number of care receivers per care giver (9.5) brings into question the feasibility of care workloads, whereby care workers in Hungary are over-burdened and subsequently not able to provide the level of care required by the elderly *(*Tróbert and Széman, 2016). While there is an emphasis on gradually shifting from residential institutional care to home help, the separation of the social services system from health system has caused many difficulties in Hungary. General practitioners and hospital specialists are often not informed about available social services with poor communication between the various services *(*Tróbert and Széman, 2016). Moreover, strains on the system has seen the use of care services decline by around 10 percent among new applicants, resulting in those with limited needs being excluded from receiving care (Czibere and Gál, 2010).

The funding allocated to support home care with alarm systems has been gradually reduced at the same time as provision having been centralised in 2013, giving rise to numerous problems. Two further changes

in regulations[73] restrict the activities that can be performed by home care workers and changed the administrative tasks and activity-based remuneration of the carer. The second regulation now divides activities into two groups: social help and personal care. One the one hand, the new regulation has seen a number of different services included in the list of approved activities (such as accompanying carers and maintaining contacts). Conversely, other activities have been removed from the list of approved activities (such as hanging out washing) (Tróbert and Széman, 2016). Activity-based care, combined with low pay, has had a negative impact on the relationship between care receivers and care givers, making the carer's work more difficult and more stressful (Tróbert and Széman, 2016). Particularly in smaller villages, in remote regional locations and among the disadvantaged with low incomes, local governments have found it difficult to ensure basic services to enable the elderly to remain in their own homes for as long as possible (Tróbert and Széman, 2016).

In the case of the second pillar of long-term care in residential institutions, stricter conditions for eligibility since 2008 have meant those admitted to residential institutions have generally very poor health and/or complex medical needs. Nursing and medical needs are increasing at the same time as staffing conditions are deteriorating. Because the care system is unable to meet demand, additional burdens are placed on family members, who are not being provided with adequate support (Tróbert and Széman, 2016).

The institutional context in which the homecare sector in ***the Netherlands*** operates is complex. Homecare (*thuiszorg*) is comprised of four elements: medical care, personal care, assistance and domestic help for people who need help in the home (Keune and Koene 2017). Shaped by historical trends and social conditions, the philosophy underpinning the Dutch healthcare system is based on a number of universal principles including access to care for all, medical insurance for all and high-quality health care services.

The Dutch homecare sector has been subject to many changes and reforms in recent years. At the current time it has three legislative and financial foundations. Medical and personal care are regulated by the *Health Care Insurance Act* (*Zorgverzekeringswet; ZVW*), in what might be described as 'regulated competition', and is financed through compulsory health insurance, which was privatised in 2006 (Keune and Koene, 2017). Most of the private health insurance companies in the Netherlands say they are not-for-profit cooperatives (albeit many have built up quite substantial reserves) that allocate any profits to the reserves or return them in the form of lower premiums. Recently political considerations have led to a slowdown in further marketisation and continuation of blocking of profit distributions to shareholders, with the possible intention of never allowing it (Keune and Koene, 2017). In some cases, individual contributions are required (Keune and Koene, 2017).

The Long-Term Care Act (*Wet maatschappelijke ondersteuning, WMO*) regulates assistance and domestic help, which became the responsibility of the municipalities in 2015 (Keune and Koene, 2017). This decentralisation was accompanied by a reduction of around one-third in the funding available for assistance and domestic help. It is the responsibility of the municipalities to support the self-reliance of those who cannot do this on their own and may include domestic help (cleaning, cooking, etc.), adaptions in the home (e.g. stair elevators), transport, social activities, wheelchairs and so forth. Under certain conditions, this can be done via a personal budget. The type of assistance is personalised and increasingly the idea is that this kind of home support will only be provided when there are no possibilities for informal care arrangements or where the support needed is beyond the capacity and capability of such

[73] Regulation No. 1/2000 that took effect on 14 January 2015 and Regulation No. 26/2007 that took effect on 3 December 2015.

arrangements (Keune and Koene, 2017). When home care is needed, a visiting nurse will assess which type of care is required and connect with the relevant medical and social domains (Keune and Koene, 2017).

The sector has been subject to a long series of reforms, budget adjustments and other recent changes. Reforms have been motivated by austerity motives (including curbing the increasing share of healthcare expenditure as a proportion of total government spending), the goal of the 'participatory society' (including the idea that those that those individuals needing care continue to live at home for as long as possible, with necessary bespoke support) and longer-term objectives such as fostering competition in the sector - between both health insurance companies and providers (Keune and Koene, 2017). These changes have often been at the centre of public debate, particularly because care is for traditionally more vulnerable groups in society and there are concerns that members of these groups may not receive proper care in the future (Keune and Koene, 2017).

In general, healthcare expenditure in the Netherlands has been under pressure in recent years. While public expenditure on healthcare has remained stable since 2012 at 14.5 percent of GDP, it has been increasing quite strongly in absolute terms and as a percentage of total government expenditure. Because of the increase in costs and as part of general austerity policies, the Dutch government has made stabilisation and reduction of health expenditure an important objective (Keune and Koene, 2017). With demographic ageing, and since the elderly make up a large share of homecare clients, it is often argued to be main explanatory factor for the rise in healthcare expenditure (Keune and Koene, 2017).

Reducing relatively expensive institutional care in hospitals and retirement homes is a key public policy objective. Hence there is a push to increase first line medical care and the self-reliance of people living in their own homes for as long as possible (Keune and Koene, 2017). Many municipalities have faced criticism for trying to reduce the support provided due to financial constraints and recently, a number of elderly and sick people who lost previous support (particularly domestic help) have taken their cases to court. Decisions from the courts have resulted in the obligations for municipalities to expand (reinstate) their levels of domestic support. Municipalities have exerted downward pressure onto providers, resulting in lower wages and job loss because the providers cannot or do not want to reduce their rates (Keune and Koene, 2017).

In the Netherlands, there have been fluctuations in the number of homecare jobs and concerns about the quality of these jobs. There are a total of 24 private health insurers in the Netherlands who are responsible for delivery as regulated under the *Health Insurance Act (*Keune and Koene, 2017). There are roughly around 400 municipalities in the Netherlands who are responsible for enforcing the *Long-Term Care Act* and the *Youth Act (*Keune and Koene, 2017).

In the period from 2008 to 2016 the total number of companies in the Dutch home care sector increased more than seven-fold from 1,680 to 12,555 (CBS, 2016). This large increase in the number of providers largely stems from a dramatic increase in the number of self-employed persons (without other employees) who have become active in homecare. In 2008 there were only 1,180 self-employed (without other employees). By 2016 this number had risen to 11,745. In addition, the number of companies with between two and 50 employees also increased; albeit not increasing as fast as sole operators. By contrast, the number of companies with 100 or more employees declined from 105 to 80; with downsizing and bankruptcies (CBS, 2016). The sometimes tumultuous developments in the sector are exemplified by the bankruptcy of TSN in 2015. TSN was a large national domestic help organisation employing 10,000 domestic help workers. Following bankruptcy, in 2016 about half of its activities were taken over by Buurtzorg and the other half by local solutions where municipalities made a agreements with smaller,

sometimes new, organisations to secure the continuity of help provision to its former clients. Despite all the changes there are still a number of very large companies in the sector, such as Stichting Buurtzorg[74] with some 9,300 homecare employees (Keune and Koene, 2017). Home support (and previous TSN activities) were placed in a separate unit (buurtdiensten[75]). Some large employers are part of multinational companies, such as Incluzio: a company active in all areas of homecare, and part of the multinational Facilicom Services Group (FSG) which is also active in the UK, France and Belgium. In addition to homecare, FSG is also active in construction, safety and cleaning. All in all, the sector is becoming increasingly fragmented in terms of the number and size of providers (Keune and Koene, 2017).

In terms of employment, the Dutch homecare sector had some 144,000 employees in 2015 and over 90 per cent of the workforce are women (AZW, 2014; van Essen et al., 2015; Keune and Koene, 2017). Total employment has decreased by some 18,000 between 2011 and 2015, despite having increased by around the same amount during the five-year period from 2006 to 2011 (AZW, 2014; van Essen et al 2015; Keune and Keune and Koene, 2017). A number of large providers are facing difficulties, while some new entrants are experiencing rapid growth. Given the recent fluctuations in employment and because it is not yet known how recent reforms will play out, it is difficult to accurately forecast future employment levels. This is made more difficult because it is not always clear which sector a job or worker belongs to, because some providers also operate across other sectors such as cleaning (Keune and Koene, 2017). However, in the short-term a serious shortage of qualified workers in the field of home care is foreseen given demographic developments.

In terms of education level, in 2014 around three-quarters of employees in the Dutch care sector belonged to the VVS professional group (nursing, caring and social-agogic). In addition, there are a variety of social workers as well as a large group of other employees (Keune and Koene, 2017).

In the ***UK*** (specifically *England*) the social care system (of which homecare is a part) is separate from the health system: the National Health Service (NHS). The NHS is free for all at point of use, its budget is ring-fenced, it is paid out of general taxation and it is devolved to each of the four nations of the UK (Green, 2016). Social care in England is provided through local authorities acting as commissioners, its budget is not ring-fenced and it is both means-tested and needs-tested.[76] Only a minority of individuals are eligible for publicly funded care (with this proportion varying geographically in accordance with socio-economic characteristics and the health of the resident population) (Green, 2016).

The foremost challenge facing providers of care in England is a continuing downward pressure on local government and social care budgets. Despite some local differences between commissioning authorities, budgets are generally tight in all commissioning areas, albeit the extent of tightness varies (Green, 2016). Results from a survey of councils in England and Wales that was conducted by the Local Government Information Unit found that more than 40 per cent of all local councils anticipated making cuts in frontline services which will be evident to the public, rising to 71 per cent among social care commissioners. More than half considered adult social care to be the most pressing issue (Butler, 2017). Despite an ageing population, real expenditure on social care in England fell by 7 per cent between 2009-10 and 2013-14. One of the ways this was achieved was by tightening eligibility thresholds for publicly-funded social care,

[74] A literal translation is 'neighbourhood care'.

[75] A literal translation is 'neighbourhood home support'.

[76] As at July 2015 people with assets of more than £23,250 have to pay the full cost of their social care.

and passing the financial squeeze on to care providers by negotiating lower prices for the care they finance.[77] This results in homecare providers trying to deliver high quality care for less and less money. The strain of the combination of continuing underfunding of adult social care, the significant pressure of an ageing population and the National Living Wage (i.e. the statutory minimum wage floor) is evident in the pressure on the homecare provider market. A study by consumer watchdog Health England published in August 2017 pointed to four areas in which people's experiences of service could be improved: care planning, skills and qualifications, consistency and continuity, and communication and feedback. The tight budgetary environment has led to 95 UK local authorities having had homecare contracts cancelled by private companies as they can no longer afford to deliver them. In March 2017 it was estimated that around one-quarter of the UK's 2,500 homecare providers were at risk of insolvency and almost 70 had closed down in a three-month period.

In England, across the industry there has been a shift away from direct provision from in-house local authority care teams towards greater private and voluntary sector provision of social care services (Green, 2016). The majority of care is provided by private providers, even if it is publicly funded.

Regulatory structures are important in social care. Homecare providers in England are regulated under the Health and Social Care Act 2008 by the Care Quality Commission (CQC) (Green, 2016). New regulations came into force in April 2015 including new standards covering the conduct and level of training of care providers and the protection of service users. The Care Certificate was introduced to replace the National Minimum Training Standards and the Common Induction Standards in England, came into force in April 2015 (UKHCA, 2016: 21). In October 2014, the CQC introduced a new framework for assessing compliance with classifications of outstanding, good, requires improvement or inadequate (UKHCA, 2016: 22). Linked to the issue of regulation, the nature of care work in England has become more medicalised. Homecare duties have expanded to include work that was previously done by medical professionals and associate professionals (Green, 2016).

Cumulatively, these trends have resulted in a system that is crisscrossed with fault lines in how services are funded, commissioned, provided and regulated – between the nationally-funded NHS and local authority-funded social care, public and private and public funding, and private and public delivery (Humphries, 2013: 8).

The number of adult social care jobs in England in 2014 was estimated at 1.55 million (around 1.19 million full-time equivalent jobs), where around three-quarters of those jobs were held by independent employers, 8 per cent were employed by local authorities, 9 per cent worked as direct payment recipients and 6 per cent were employed by the NHS (Green, 2016). In terms of the gender structure of the workforce in England, it is predominantly female (82 per cent in 2014) (NMDS-SC database[78]). Approximately 17 per cent of the workforce in England is from a Black and minority ethnic (BAME) group background, rising to 59 per cent in London.[79] In terms of nationality, 82 per cent of the workforce is British with non-European

[77] LangBuisson (2015) calculate that local authorities reduced their fee rates by a national average of over 9% between 2010/11 and 2015/16.

[78] The NMDS-SC is an online database (see https://www.nmds-sc-online.org.uk/content/About.aspx) which holds data on the adult social care workforce. It is the leading source of workforce intelligence and holds information on around 25,000 establishments and 700,000 workers across England.

[79] In part, reflecting differences in the ethnic profile of the population in England.

Economic Area (EEA) nationalities making up 12 percent and the remaining 6 percent having an EEA nationality. In 2014, the mean age of the workforce was 43 years (Green, 2016).

Around three-quarters of the adult social care jobs were involved with direct care, including care workers, senior care workers, support workers and jobs for direct payment recipients. In addition, a range of other jobs involved providing care and support directly such as community support and outreach workers and other care-providing jobs. Managerial and supervisory roles accounted for 110,000 jobs, including senior managers, middle managers, line managers, registered managers and other managerial roles not directly involved in providing care. Regulated professions accounted for 90,000 jobs including social workers, occupational therapists, registered nurses, allied health professionals and teachers (Green, 2016).

The number of adult social care jobs was estimated to have increased by around 3 per cent (40,000 jobs) between 2013 and 2014 and by 17 per cent since 2009. The proportion of direct care-providing jobs increased from 74 per cent in 2011 to 76 percent in 2014 (Green 2016). Since 2009, there has been a continual shift away from employment with local authorities towards independent sector jobs. Personalisation of adult social care is also apparent with a large increase in the number of jobs for direct payment recipients since 2009 (where the increase is estimated at around 36 per cent or 35,000 jobs). The majority of the increase in adult social care jobs since 2009 came from an increase in jobs for CQC regulated non-residential establishments (up by 40% or 140,000 jobs) and in care homes with nursing (up by 20% or 50,000 jobs) (Green, 2016).

In terms of skills and qualifications, implementation of a regulatory framework on social care in England in the early 2000s had a positive effect on the level of training and qualifications in the sector. In 2012, 84 per cent of UK care sector employers reporting providing training for their staff, compared with 59 percent across the whole of the UK economy (Skills for Care & Development, 2013). However Gospel and Lewis (2011) suggest that few UK organisations have combined training with a broader set of human resource management practices of the kind required for a high performance work system.

From these national overviews it is relevant to note that the precise roles and activities included within what is conventionally understood as the homecare sector varies between countries. In the Netherlands there is a four-fold distinction between medical care, personal care, assistance and domestic help for people who need help in the home. This is a broader range of activities than in the UK and Hungary where the health and (social) care systems are separate. In the UK personal care is the main activity within the homecare sector. Older people who can afford to do so might pay for companionship services. Other than help with meal preparation and serving, domestic help tasks (such as cleaning, etc.) do not fall within the auspices of homecare. Likewise, medical care other than tasks such as ensuring clients take medication, are not routinely classed as homecare. In Hungary there is a key distinction between social help (i.e. domestic tasks) and personal care.

1.2 Generic factors influencing the development of the care sector across countries

From the national accounts above it is clear that there are several generic interlinked factors influencing the development of the care sector across countries.

First, in all European countries there are *ageing populations*, albeit the rate at which ageing is occurring varies. For example, in the Netherlands the share of persons aged 65 and older has been increasing rapidly, from 7.7 per cent of the total population in 1950 to 11.5 per cent in 1980 to 13.7 per cent in 2000 to 17.8 per cent in 2015. Moreover, population projections point to continuing growth in the numbers of older

people. This growth is important for any consideration for care of the elderly. However, not only are there greater numbers of older people, so leading to a greater need for care *ceteris paribus*, but the elderly tend to have more complex needs as they grow older (i.e. the nature of demand for health and care is changing), such that appropriate care provision might be more complicated also, so presenting challenges for the sector.

As the needs of older people have become greater, which has been reflected in a greater 'medicalisation of care', there have been pressures both enhanced integration of care and health and greater collaboration between service deliverers. This *blurring of boundaries* poses both challenges and opportunities for care providers. On the one hand integration means there is scope to create more coherent progression pathways for carers to work in health-related roles, while on the other there is greater space for distinguishing between domestic help, personal care and healthcare related roles (i.e. greater segmentation of tasks). More complex needs of care beneficiaries (i.e. 'clients') mean that for the maintenance of good quality care for elderly people collaboration between different parts of the care and health systems, and between providers, is crucial; working well together matters. Changes in other parts of the wider system – notably in health services, welfare and benefits, housing and well-being policy domains - have important implications for care.

More older people, and their more complex needs, place greater demands on funding for care. The *challenges of financing care* have implications for the balance between different kinds of care provision. There is pressure for individuals to move out of hospital sooner and to live independently in their own homes for longer. This means that individuals in their own homes are in need of additional care, as the care requirements they present with are more complex than was formerly the case. Financial pressures at the macro economy level mean that there have been cuts in public expenditure, so creating financial pressures for the case system. Reductions in funding have meant increased stringency in criteria for care support – such that the profile of those eligible for publicly-funded care is skewed more towards the neediest than was formerly the case. Ongoing challenges of insufficient funding put the care system under pressure, and these can be exacerbated by uncertainties about funding level changes.

Cost factors are one driver of a policy emphasis on *older people living independently in their own homes for longer* (with social care [and health] support), rather than being in hospital or moving into residential care. This means the care system has to deal with individuals who might formerly have been in hospitals. Well-being factors also drive in the same direction towards independent living and underlie a trend towards greater emphasis on client-focused care as opposed to more standardised care delivery. The wish to improve self-reliance, driven by a combination of cost-factors and client well-being, is an important factor driving both technological and (mainly) organisational innovation.

Older people in need of care tend to be vulnerable. This means that *the care sector is regulated, with minimum quality standards set*. As revealed below, regulation can be a driver of innovation as care organisations innovate to meet/ improve standards of care – for example as certain minimum skills requirements can drive investment in training and development of staff. Conversely, overbearing regulation, or frequent changes in regulations, can stifle innovation by restricting room for manoeuvre.

In general *implementation of technology* to support carers/ older people is less advanced in the care sector than in health (although there are variations between countries and organisations). Technology can play a role in monitoring the condition of care clients and in bring healthcare applications within the scope of care. It may also facilitate administration, planning and processing of care visits.

2 Case studies, key features of the care sector and main findings

This section outlines key findings from case studies undertaken across the three countries (for further details see the Annexes). Section 2.1 introduces the case studies, section 2.2 outlines key features of employment and job quality, and associated implications for social inclusion, and section 2.3 showcases specific examples of organisational and technological innovations, outlining in each case associations with job quality and employment outcomes and implications for social inclusion. The case studies involved interviews with managers and workers, and were supplemented by interviews with other directly relevant stakeholders. Reflecting on the evidence presented in this section, inter-relationships between innovation, job quality and employment are discussed in the round in the following section.

2.1 Introduction to the case studies

Empirical case studies of care organisations/companies involved in-depth interviews with managers and workers, and were supplemented by interviews with other directly relevant stakeholders and experts. The interviews explored business strategies, market segments of operation, details of employment, approaches to job quality, challenges faced and important innovations planned/implemented in the recent past. A particular focus was on investigation of inter-relationships between innovation and job quality, employment and social inclusion.

Table 1 outlines the nature of the case study organisations and the number of interviews undertaken in each case.

Table 1: Overview of case studies

Pseudonym	type of company / establishment	number of employees (< = 50; 51-500; 501-2500; > 2500)	number of interviews	case study storyline
HU-SOCIAL INSTITUTION	United Social Institution providing integrated social services in a relatively small local municipality – the focus of the case study is on the Home care unit	< 50	3 interviews (of which 1 focus group with 5 employees)	Poor job quality as a hindrance for innovation
HU-CHURCH PROVIDER	Historic church providing social care services in a city in a peripheral part of Hungary	51-500	3 interviews (of which 1 focus group with 8 employees)	The role of supportive management in enriching intrinsic job quality
HU-GOVERNMENTAL PROVIDER	Provide care services for elderly people in a city in a peripheral part of Hungary	51-500	2 interviews (of which 1 focus group with 8 employees)	The vicious cycle of constant underfinancing, a bureaucratic organisational culture and labour shortage
NL-HOME CARE	Regional healthcare organisation with separate divisions providing welfare, care, living and comfort services across 20 local municipalities. The focus of the case study is on the Care Division	501-2500	11	Working towards self-organisation and smart co-operation around district nurses to improve local effectiveness combining holistic client support with specialIsed actor inputs
NL-HOME SUPPORT	Home support unit of large regional home care organisation providing home support services (mostly cleaning)	51-500	12	Attempting to integrate home support activities in a home care organisation undermined by ambiguity about ambitions for home support services
UK-FAMILY PUBLIC	Private family-owned care company, delivering a publicly-funded block contract in four towns in a semi-rural area of England	51-500	6	Good intentions undermined by external constraints
UK-FRANCHISE PRIVATE	International company operating local franchise model (with multiple franchises in England) delivering privately-funded care supported from a National Office – interviews at National Office and at two franchises ('1' and '2') in 'Middle England'	51-500 (per franchise)	12 (across National Office and two franchises)	Leadership and management for a high-quality proposition: central guidance with local delivery
UK-METRO PUBLIC	A private care company trading under its own name but part of a wider group, delivering publicly-funded care for several different commissioners in an ethnically diverse metropolitan area	51-500 (in branch)	7	Commissioner: contractor collaboration for ethical care in a diverse metropolitan environment

Source: Own compilation based on case study reports (see the list of reports in section 6 of this chapter).

2.2 Case study evidence on key features of employment and job quality

This section outlines key features of employment and job quality, and associated implications for social inclusion, in order to set the context for the discussion of innovations in 2.3, which in turn impact on employment, job quality and social inclusion.

2.2.1 Employment characteristics

The workforce in care is overwhelmingly *female*. In terms of *age*, while offering employment to all age groups, the sector is relatively unattractive to younger workers, with many jobs filled by middle-aged and older workers. Despite some local and national variations, the care sector has relatively high proportions of workers who are *non-citizens* and/or who are from *minority groups* (this is especially the case in the UK, although in the Netherlands in areas close to the border companies are also looking outside the country for labour).

The care workforce is relatively *low-skilled* as measured by formal qualifications required on entry and in performance of standard carer roles in the UK and Hungary and for home support roles in Hungary and the Netherlands. Often a greater emphasis is placed on a 'caring disposition' than qualifications or experience in recruitment, albeit the general trend is for an increase in skills requirements from a low base. Indeed, in the Netherlands the levels of entry qualifications required is higher for carer roles than in the UK or Hungary, and there is an increasing differentiation between carer roles that require an increasing level of formal vocational training and home support jobs. Whereas in the UK after a short induction course and work shadowing carers can go out and deal with clients and undertake further training (e.g. for a Care Certificate) on-the-job, in the Netherlands the norm for carers would be to have undertaken a three-year vocational training course, while nurses will have undertaken vocational training at levels 4 or 5.[80]

The sector is characterised by *ongoing recruitment and retention challenges* – such that some care organisations are recruiting on a continual basis. This was the case for all three case study organisations in the UK, while in the Netherlands labour shortages were reported to be particularly pronounced in NL-HOME CARE from summer 2016 for carers and especially for nurses in the face of pressures to upgrade positions to deal with more complex care requirements and proactively manage and activate the informal care network (Balhuizen and Koene 2017).

2.2.2 Job quality

Turning to consideration of the *QuInnE indicators of job quality*, in terms of *wages* pay levels are low relative to the national average. This reflects both the skills profile of carers and the financial pressures on the sector. Variability in pay tends to vary according to whether workers are on guaranteed hours contracts (as is the norm in Hungary and the Netherlands) or on zero hours contracts (which are common in the UK) (Gardiner and Hussein, 2015).

With regard to *employment quality* the case study evidence indicates that in general care workers have continuing employment, even if they are not engaged on a permanent basis. This reflects the fact that

[80] In the Netherlands formal qualifications required for carers and nurses are as follows: Carer level 2: 3 years level 2 vocational training carer –allowed to do cleaning, give coffee, give out food, etc.; Carer level 3: 3 years level 3 vocational training carer – allowed to wash, dress, people, do basic medical activities, etc.; Nurse level 4 vocational training - regular nursing activities; Nurse level 5 higher vocational training – required by district nurses.

there are not marked variations in the volumes of care required once contracts have been awarded; rather the demand for care is such that most care workers are secure in their jobs and (in most areas) could find similar work elsewhere. In the Netherlands, while there has been a good deal of turmoil in the market and bankruptcies recently, there is a growing shortage of care workers and so possibilities for continuing employment. Traditionally internal progression opportunities have been limited given relatively flat organisational structures. Nevertheless, there are examples of carers in the UK being promoted to supervisory and management positions. However, greater integration of care and health offers opens up more opportunities for progression (with some level 3 carers being able to advance with further training to level 4 and level 5 nursing positions in the Netherlands in NL-HOME CARE), and where care organisations include domestic (e.g. cleaning) functions as well as care functions (as in Hungary) there are examples of internal progression. At the same time, the NL-HOME CARE example shows that this progression is limited to workers that can make a step from home support/domestic help to care roles that require further formal training. For workers on guaranteed hours weekly hours are generally predictable. For those on zero hours contracts in the UK working hours can be less predictable, but then workers can choose whether or not to work at certain times. Since carers are out in the community presence at a central workplace is not applicable; however, in another sense presence is extremely important as clients expect/are dependent on visits at certain allotted times. There is evidence for some involuntary long hours working where there is insufficient time scheduled to undertake all tasks that carers would wish to do and carers complete such tasks (or related administrative activities) in their own time. There is more limited evidence of involuntary part-time work which is most likely to occur for new recruits when they are becoming established.

Turning to *education and training,* aside from basic literacy and numeracy, formal education standards are low for domestic/home support roles in Hungary and the Netherlands and for carer roles in the Hungary and the UK. However, regulatory frameworks set minimum standards and case study evidence indicates that care organisations can be keen to provide non-mandatory training in order to better equip workers to fulfil their roles and to raise standards of care. Skills acquired are transferable within the care sector and have some relevance in related sectors. At least one case study care organisation emphasised the importance of inducting new staff with previous care experience in 'their way' of doing things. Refreshment of certain skills on a regular basis is compulsory. Some case study organisations provided ongoing learning opportunities for additional specialisms. This reflects that fact that given the more complex care clients need at home, care providers are looking to raise the skills levels of carers.

A key feature of *working conditions* is that care workers and individuals undertaking domestic activities in clients' homes tend for the most part to work alone. At face value this affords them a certain amount of autonomy, but traditionally the particular tasks to be undertaken have been specified. Financial constraints can mean that the determination of 'allowable tasks' has become more stringent, whereas in the Netherlands case study focusing on home help (NL-HOME SUPPORT) the direction of travel is in the opposite direction with greater discretion expected of workers to determine priorities. The latter is in accordance with a shift towards greater client-focused care. Semi-autonomous teamwork is evident in the Netherlands case studies where there are self-organised teams (NL-HOME CARE) (see section 2.3 for further details), but not in the Hungarian and UK case studies. Job variety in care tends to come more from dealing with different clients than in terms of the range of tasks performed, but the shift to person-centred care brings with it greater job variety. Work intensity is high given the schedules to which carers work and the fact that the needs of clients are increasing on average. The fact that caring and domestic help are physical roles and that clients may display challenging behaviours in emotionally-charged situations raises

the risk of care workers suffering physical and psychosocial problems. As 'lone workers' in general care workers have limited opportunity for interaction with others performing similar roles. The additional responsibilities of the workers increase their need for organisational support in dealing with growing complexity and discretion. Case study evidence indicates that care organisations are working to increase supervisory, and especially peer group, social support (as exemplified by the organisational champions described in section 2.3.1). However, especially in the lower-skilled roles in the Netherlands, cost pressures have led to growing responsibility and pressure without concurrent development of adequate organisational support.

Turning to *work life balance*, work scheduling in the care sectors is dictated by the fact that some clients need care at certain times of day (e.g. often in the morning for help with getting up/having breakfast, at lunch-time and in the evening) every day (including weekends), so leading to split shifts (morning and evening) and regular weekend work. Domestic help is generally undertaken in what might be considered conventional 'normal working hours'. To some extent, within the constraints of when care has to be delivered, workers (especially those on zero hours contracts) can say when they are available to/would prefer to work, and can be rostered accordingly. While this suggests some degree of working time flexibility, once a worker is rostered and a schedule of care visits is set, workers have very limited control over their hours. If an individual cannot fulfil a visit it has to be allocated to someone else. Case study evidence indicates that it is often the case that carers find they cannot fit in all of the tasks that are required and/or that they would like to do to a standard of which they could be proud, within the allocated time. Especially in the case of home support, workers often have long-standing relationships with their clients, and feel a responsibility to them, more than to their (sometimes more transient) relationship with care organisations. This means that work (especially but not exclusively administrative tasks), can spill over into non work time.

The case study evidence suggests that *consultative participation and collective representation* in the care sector is relatively poorly developed, with no/low direct participation in organisational decisions. Formal worker representation and trade unions are relatively weak in the care sector, although there are variations between countries. In the UK the privatisation of care helps explain low levels of unionisation (even in a UK context), although trade unions have helped to influence debate about employment standards (as the example of the Ethical Care Charter outlined in section 2.3 illustrates). In Hungary the norm is for a lack of trade union involvement, although in the case of public sector providers it is compulsory for a public servants council to exist. The influence of trade unions and works councils is greater in the Netherlands where a sector-wide collective agreement is regulating a wide variety of pay and working conditions and works councils are active and play a key role in specifying a number of issues that are part of the collective agreement and adapt them to the reality of specific organisations (such as training and development, and certain elements of remuneration and reimbursements). At the same time, the big market changes that the care sector has been facing (cost pressures, requirements for more inclusive/patient-centred care, changing funding streams, etc.) and the growing number of very small organisations has limited the impact of individual employee participation in traditional organisations (Keune and Koene 2017).

Taken together, the characteristics outlined above point to *poor extrinsic job quality* in care. Yet the case studies (and the wider literature) point to *high intrinsic job quality*, with workers in care tending to value their role in helping their clients and making a difference to their lives. Hence the care sector presents an interesting juxtaposition low extrinsic and high intrinsic job quality.

2.2.3 Implications for social inclusion

So what does this mean for social inclusion? The '4S' framework devised for QuInnE (Warhurst et al. 2016) to categorise different facets of jobs that are important for social inclusion distinguishes:

- **Stepping stone jobs**: offering entry into paid work
- **Sticky jobs**: offering sustainable employment
- **Springboard jobs**: offering routes to better jobs either within internal or external labour markets
- **Stretchy jobs**: offering work and employment that extends working lives

The relatively low barriers to entry[81] and high expansion and replacement demand for carers means that care provides stepping stone jobs in abundance. Individuals who find that other employment opportunities are closed to them because of a lack of qualifications or where local labour markets are slack, can often find job opportunities in care.[82] However, organisational innovations aimed at self-organisation (in the Netherlands) and the increasing responsibilities for care workers (more generally across the three case study countries) make care work more demanding. If qualification requirements for care workers are raised as a result, especially in the absence of provision of any additional organisational support, barriers to entry are likely to increase.

Ongoing labour shortages in care in many areas, together with increasing demand as the population ages means that care can provide sustainable employment. Care jobs tend to be sticky jobs.

The extent to which care jobs are springboard jobs offering routes to better jobs is less clear. As mentioned in passing above and the case study evidence in section 2.3 shows, there are good examples of instances of where and how workers in care can progress (albeit progression might not reap significant [or indeed any] financial reward). Trends towards the integration of health and care and also towards greater medicalisation of care, in theory offer opportunities for progression. However, such progression routes are not always clear. Furthermore, there is likely to remain a significant demand for conventional care roles in the short- and medium-term.

Care jobs can be stretchy jobs– albeit some tasks can be physically demanding. The fact that care work often can be undertaken on a flexible/ part-time basis means that in work organisation and scheduling terms care jobs can be fashioned in such a way that can be stretchy. Life experience can be an asset in care and some of the case study organisations specifically championed older workers, while recognising the benefits of a multi-generational workforce.

Hence the features of the care sector – sometimes reinforced by the proactivity on the part of care organisations – suggest that it is (and has potential to be even more) a socially inclusive sector.

2.3 Showcasing innovative practices from the case studies

The findings from the case studies are organised by showcasing case study examples of two main types of innovation – organisational (section 2.3.1) and technological (section 2.3.2). Implications for job quality, employment and skills are drawn out in each case; (these are explored further 'in the round' in section 3).

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[81] One interviewee in the UK remarked that there was a prevailing feeling amongst some segments of the public that caring is something you do "*if there is nothing else you can do*".

[82] Albeit they might not possess personal attributes that mean that they are suited to working in care.

In general, the case studies highlighted more examples of organisational innovation than of technological innovation – although it is important to note that (at least in some cases) technological innovation may require associated organisational innovation to be effective – and to enhance job quality. Hence organisational innovations are considered first.

Overall, it is apparent from the showcased examples of organisational and technological innovation outlined above that *key drivers of innovation* in the care sector include:

- *regulation and regulatory changes* - care is a relatively highly regulated sector given that society/political norms acknowledge that care is being provided to vulnerable people;
- *market changes* - in terms of how care is commissioned and by whom;
- *cost savings* - reflecting the financial pressures on the sector in the context of austerity at the same time as an ageing population brings greater demands;
- the *needs of care recipients* (referred to as 'clients') ;
- *organisational ethos*; and
- the development, introduction and demands (on the organisation and on the workforce) of *new technologies* – which can facilitate planning, provide potential solutions for increasing productivity in care, but also can increase the complexity of care work (especially as hospitals and nursing homes deal increasingly with the most severe cases only).

2.3.1 Organisational innovations

Five types of organisational innovations are showcased in this section: a general shift in focus from 'time and task' to 'outcome related' care; enhanced support for carers (and their clients) –through (1) training and development, (2) stress management, and (3) peer support through organisational champions; collaborative working; innovation in organisational models and the development of self-organised teams; and an initiative to 'raise the floor' in an attempt to enhance job quality of carers and the quality of care for clients.

2.3.1.1 From 'time and task' to outcome-related care

Traditionally in the UK and Hungary care that is publicly funded has been organised on a *'time and task'* basis– i.e. care requirements are prescribed at the outset (by a social worker/nurse) and a care provider is contracted to deliver the care specified for a given price. In this model the carer has to complete specific tasks in the time available (or as many of them as is possible); any additional input has to be undertaken in their own time, so infringing on the work-life balance of care staff. *Outcome-based care* looks at care more holistically from a client perspective – and this tends to be more demanding of carers', supervisors' and managers' skills. Hence in the care sector there needs to be an onus on continuing skills development to deliver personalised quality care. However, shifting from 'task-based' to 'outcome-based' care is not necessarily straightforward, as the following example shows.

Led by a local commissioning authority in England, in what was termed an 'innovation', UK-METRO PUBLIC had an 'outcome-focused contract' from one of its several local authority commissioners (Green and Wright, 2017). Under this contract for each client the care supervisor was given a pot of money to do an assessment and make a plan based on spending that money in such a way as to promote the client's independence as much as possible. Rather than care plans being fixed for a year, the aim was for outcome-focused contract to be reviewed – and adjusted as necessary – every 12 weeks. Additionally, there were expectations that UK-METRO PUBLIC should incorporate various community services to help support the individual client:

> *"So they would say we expect you to reach out to Age Concern, for example, and get a befriender in here for a Thursday afternoon [for Mrs Jones]. … We expect you to reach out to X workshop down the road so Mr Jones can go down and do a bit of carpentry on a Friday." (Area Manager, UK-METRO PUBLIC).*

While this outcome-focused contract was considered good in principle, it had proved difficult to operationalise in practice. First, skills additional to those typically required by (or possessed by) supervisors are necessary to manage such packages; hence extra training is required for a more demanding role – but such training was not immediately forthcoming. Moreover working in this way would require upskilling of carers too to execute more varied roles. Secondly, support services/ charities were very stretched and so found it difficult to offer any resources of the type desired for additional client support. Thirdly, existing invoicing arrangements demanded by the commissioning authority were too standardised to cope with the flexibility of outcome-focused contracts:

> *"Government money has to be accounted for and how those systems work is very standardised. You have to produce an invoice and that invoice has to say it will spend at this time on this date. That invoice at the very most you're looking at a month so within that month you can't bank the money and use it another time because within that month you have to know that money's been used. If the money hasn't been used they'll take it off." (Area Manager, UK-METRO PUBLIC).*

At the time of the fieldwork, UK-METRO PUBLIC was working with the local authority in question to try and address some of these issues. However, this case exemplifies how external constraints associated with public financing arrangements and additional skills requirements for workers can impede innovation that might enhance the quality of care for clients.

A similar dynamic is found in the Netherlands in NL-HOME CARE (Balhuizen and Koene 2017). To assess individual clients needs NL-HOME CARE introduced the role of the district nurse (in cooperation with other regional care providers) with special additional responsibilities in holistically assessing client needs and with the explicit responsibility to advise clients about all support and care possibilities available in the neighbourhood. The district nurse's activities recognised the interdependency between local care providers and the value of taking a holistic, outcome-oriented perspective. However, long-term funding for these activities is difficult as regular funding is provided on a 'time and task' basis. To date the district nurse activities have been funded as part of the 'visible link' innovation programme in home care[83] and explicitly distinguished as 'S1' activities, separated from executive care 'S2' activities. With the ending of this programme, two large insurance companies have offered to keep financing the activities of the district nurse cooperative, but the future of the programme is uncertain as the market doctrine does not recognise the value of co-operation (as outlined further below):

> *"It's annoying that we are still in between two paradigms. [...] co-operation [...] would better fit this participation co-operation, the whole view. At the same time, of course, we have brought the paradigm of competition in care. And that's a dominant position, insurers compete with each other. And those insurers ... aim to contract the best providers and buy it under the best conditions. And this creates competition. [...] What we actually say to all insurers: now pay one party to arrange things in a specific district, because that is clear for the*

[83] The 'visible link' programmes are from the Netherlands Organisation for Health Research and Development.

GPs and for everyone, and then the customer can still choose [between] home care providers. […B]ut let one person do this piece of infrastructure. If every insurer says no, I pay everybody a little bit and then everyone can do it a little. Yes, then it will not work." (member of the executive board, NL-HOME CARE).

2.3.1.2 Enhanced support for carers (and their clients)

(1) Investments in skills development**:**

More generally, case study organisations emphasised the need for investment in skills development for employees to deliver better outcomes for clients. As noted above, typically positions in the area of domestic help do not demand formal qualifications and so are open to all. Hence recruits to the sector in such roles need not have any relevant experience or prior training, albeit the situation is different for carer roles with a healthcare/medical element and varies between countries, with qualification demands being highest in the Netherlands.

The demand for carers and relatively poor extrinsic features of job quality mean that even when there were very limited opportunities in other sectors, openings in care remained: the care sector is socially inclusive. In Hungary, for example, a significant number of employees were reported to come from sectors suffering job losses where low-skilled employment had dominated; the care sector provided a route back to sustainable employment for the unemployed (i.e. care provided 'stepping stone' and 'sticky' jobs). In Hungary HU-CHURCH PROVIDER employed so-called 'public employees' (i.e. unemployed persons willing to work) in auxiliary tasks in care; legally public employees are not permitted to work in nursing and caring tasks and so job roles have to be designed as to separate 'caring' and 'auxiliary' tasks). With some training alongside their work duties, it was reported that around half of public employees graduated into work as 'carers'. (Patyán et al. 2017a). This strategy can be conceptualised as offering 'wins' all round: the unemployed (especially older women) are integrated into work and can progress into a caring role, heavier auxiliary tasks can be removed from the workload of carers and the employer can identify and train suitable recruits as carers.

An interviewee in her fifties who had previously worked in accounting and book keeping had become unemployed when her previous employer closed down and when professional short courses failed to help her find a job turned to the care sector, using her social connections as a member of an ecclesiastical committee to gain entry to the sector as a public employee before graduating to become a carer:

"Finally I realised that I have no other choice to find a job at my age, except to work as a social caregiver. The age doesn't matter that much in this area. There are many ladies here who are near to the pension age." (Carer, HU-CHURCH PROVIDER).

Albeit this represented some downskilling in relation to this individuals her previous employment, the care sector in Hungary offers employment opportunities for older workers.

In the light of the inclusive nature of the care sector, care organisations necessarily have to ensure that workers are trained to meet minimal quality standards and further training is likely to enable higher standards of care to be delivered. At face value this suggests that unless domestic-related tasks are separated out from care tasks – as in the case of HU-CHURCH PROVIDER – the care sector is likely to become less inclusive for the least skilled. Moreover, training needs to be adapted to the needs of the workers.

In the UK UK-METRO PUBLIC has a diverse workforce drawn from various different ethnic and language groups (Green and Wright, 2017). Some carers have gravitated towards the sector because of no/low formal qualifications (often associated with a dislike of traditional classroom-based teaching methods). As part of the shift from time and task to more outcome-related care, UK-METRO PUBLIC had introduced first, a new type of practical training focusing on consequences; and secondly, narrative record keeping. In part this was stimulated by a necessity to improve medication management in order to conform with externally imposed quality standards (i.e. regulation was a primary stimulus for innovation), but this was matched by the organisation's desire to improve the quality of care.

Rather than a conventional emphasis on 'how something should be done', a new approach was adopted in what was termed *'what happens if you don't do it training'* focusing on the consequences of poor medication management rather than on 'how to do it'. The improvements in medication management as a consequence of this more practical learning style were described by the Area Manager as having been "*immense*".

Additionally, a 'care worker medication lead' had been introduced from amongst the care workers (without promoting them – in a fashion similar to the organisational champions appointed by UK-FAMILY PUBLIC in the UK [outlined below]):

> *"We're giving them a status saying we see you as somebody who's done fantastic work in this field, whose constantly done well with medication and therefore it's like creating a champion almost. We give them additional training so that if any of their colleagues get stuck they can start by talking to the medication lead who may be able to give them a solution from the care worker's point of view." (Area Manager, UK-METRO PUBLIC).*

To provide further reinforcement, there had also been a particular focus on medication in supervision meetings.

Alongside this there was an emphasis on "*narrative*" record keeping as a way of enhancing quality standards and improving the baseline of information available for collaborative working in the light of policy drives towards integration of care and health and greater collaboration between care providers (as discussed below). The Quality Officer reported that there used to be a tendency for carers to record: "*all care given*". However, this is not helpful for knowing how the client is or for any other healthcare professionals dealing with the client. So carers with the new narrative record keeping carers are encouraged to write things like: *"The service user answered the door swiftly"* – which shows that there are not mobility problems, etc. Carers are also encouraged to write down what service users have eaten/ are eating; (this may be important if a person is taken to hospital/ requires a medical procedure, etc.)

This development serves to enhance job quality for carers but requires reasonable standards of literacy amongst care workers, for whom English is a second language for many in this case.

Innovations in learning and skills development need not be prompted by external stimuli (such as regulatory standards). In some instances the ethos of the organisation and the manager is the crucial factor in going beyond baseline regulatory and contractual requirements and so provide an enhanced quality of care. Different organisational structures and financial models also help explain differences in the room to manouevre in providing such improvements.

In the UK at UK-FRANCHISE PRIVATE particular emphasis was placed on learning and development. A central 'national office' provided a mentoring programme for new franchise owners (who generally came

from successful careers in commerce rather than care), plus ongoing support. Indeed, before being accepted as a potential franchisee the Franchise Team at national office work with psychologists to undertake psychometric testing around how well potential franchisees' attributes accord with passion and empathy, cultural fit, people orientation, attitude to risk, whether and agile learner, etc. (Wright and Green,2017b).

Likewise, in training for carers reference was made to values, validation, professional needs, and social needs (acknowledging the isolating nature of care work [as discussed further below]). In professional terms carers were encouraged to complete the 'Care Certificate' (which was developed by the industry and has set new minimum standards that should be part of the induction training of new care workers), but case study interviewees emphasised the five 'needs' (i.e. qualities) of a care giver: empathy, dependability, patience, strength and flexibility.

Illustrating the local discretion that is possible in a franchise model and the greater financial resource available in a business model based on privately- rather than publicly-funded care provision), Local Franchise 1 at UK-FRANCHISE PRIVATE insisted that all new recruits (whether or not they had previous experience in care) undertook a week's classroom-based training (which was the start of the nationally-recognised Care Certificate) and also required workers to undertake City and Guilds Training in Alzheimer's and dementia care (reflecting the particular emphasis this particular franchise owner placed on care for this 'specialism'). When carers had been with the franchise for six months they were offered the opportunity to take further qualifications in Health and Social Care (funded by the company), on the proviso that if on a modular course one of the options is on dementia, that module should be completed. The senior management team had all been offered the chance to do degrees – with no requirement that it had to be in a health-related subject, on the grounds that "*the whole process of doing a degree and the academic rigour of doing a degree and the general learning from it*" would be beneficial (Franchise Owner, Local Franchise 1, UK-FRANCHISE PRIVATE).

In an innovative development for UK-FRANCHISE PRIVATE Local Franchise 2 had appointed a Learning and Development Manager and a Learning and Development Officer to develop the franchise's people management function. Developments to date at the time of the fieldwork included making induction training more interactive and people oriented; development of 'refresher' courses on topics such as dementia, challenging behaviours, personal care and medication; one-to-one coaching; etc. Attention had also been devoted to succession planning (i.e. 'spotting' individuals who might be suited to particular management roles and developing individualised development packages for them, including projects which might be of wider benefit to the franchise).

It is worth noting that franchise owners had invested a substantial proportion of their own money in the franchise, and had a certain degree of both resource and autonomy to introduce innovations as they wished. The rationale for such learning and development innovations was to improve the standard of care for clients and provide enhanced job quality for staff.

(2) Combatting (potential) detrimental features of lone working and managing stress

As noted in section 2.1, a key feature of working in care is that (at least in most instances) the carer tends to work alone with the client. According to the extent of discretion the carer has in organising the schedule of the working day (and this can vary by organisation and country) this means that the worker may have some degree of autonomy, but traditionally there has been a lack of teamwork to provide support for lone

working (the self-organised teams in the Netherlands at NL-HOME CARE outlined below is a partial exception to this).

In all instances the case study organisations recognised that a carer's role can be physically and emotionally demanding, as described by two of the carers from Hungary:

> *"It is physical work. To put a 70-80 kg client into the bathtub and to take him out, it is not easy. To do the cleaning for five clients a day…at the end of the day I go home and I am dead tired." (HU-CHURCH PROVIDER, Carer).*

> *"We are mentally shattered. To deal with the large number of elderly, demented people ... disease…feeling of death... loss ... everyday topics. My firm belief is that after 25 years of work we should retire ... because ... because we burn out and that's all." (HU-CHURCH PROVIDER, Carer).*

Difficulties in 'switching off' from personal involvement with individual clients' circumstances and needs can mean that stresses and strains can spill over to carers' working and non-working lives, with detrimental impacts on work-life balance. It was recognised widely across case study organisations that training had a role to play in preparing carers for the demands of the job – especially as the content of the role increased from home support to caring to nursing. But on its own (ongoing) training might be insufficient; rather additional social and psychological support might be needed in some instances.

The case study organisations adopted different strategies to address these needs. Opportunities for care workers to come together with each other were universally acknowledged as important, but could be difficult to engineer:

> *"Community activities should be strengthened when they [the carers] can be together after work. Unfortunately the workload is so heavy and the deadlines are so tight that it is very difficult to do it. Everybody is rushing, running." (HU-CHURCH PROVIDER, Head of organisation).*

In the UK at UK-FRANCHISE PRIVATE considerable emphasis was placed on *"touch point"* opportunities at the central care office providing opportunities for care workers to come together in a sociable atmosphere, while also sharing experiences between themselves and with the office-based team. UK-FRANCHISE PRIVATE Local Franchise 1 had started 'Area Meetings' with fewer people (rather than larger groups) coming together and had received good feedback from that. Moving away from the central office and clients' homes, a group of staff at UK-FAMILY PUBLIC led a late summer excursion to the seaside with carers, some clients, their families and other staff in order to provide an opportunity for everyone to come together. This was seen by the owner and staff as a token of appreciation for their hard work from which all could benefit (Wright and Green, 2017b).

Another of the case study companies emphasised the importance of thanking staff for their work. In the UK at UK-METRO PUBLIC a fortnightly newsletter had been instituted (Green and Wright, 2017). While the foremost purpose was to provide work-related reminders to carers, the newsletter also provided a mechanism to thank carers for their work:

> *"It's [the newsletter] just a one sided sheet where we write little things down about, you know tips and reminders: you know how to give people ... more calories in their food to bolster their nutrition. ... It always starts with you know 'Thank you so much for the quality care you're*

> *giving our customers, thank you for working hard'. So lots of thank yous in there, lots of support and I think that's been really valuable. People will often say to me since you've been here the communication is better and so it may not sound particularly innovative, but the improvement it's made and the way our care workers feel is a real plus." (UK-METRO PUBLIC, Area Manager).*

While the strategies showcased above might seem rather small scale and informal they nevertheless represent innovations to enhance intrinsic job quality in an environment where financial and temporal resources are stretched. However, the case study research yielded an example of a more formal approach to address worker well-being.

In Hungary HU-CHURCH PROVIDER had a strong Christian ethos and placed a key emphasis on highly motivated staff (Patyán et al. 2017a). Over time management recognised the extent of psychosocial risks faced by carers given the emotional and physical demands that their heavy workload placed on them and then tested carers' burn out using the Malasch Burnout Inventory (MBI) test (i.e. a leading measure of burnout):

> *"It was at the beginning of 2016 when I noticed some workers had changed. They started to be a bit introvert, even though I asked what the trouble was they said nothing. I thought I would perform a burning out test. Then I was shocked by the results. 30% of employees had medium or high level burnout symptoms. Certain people went on [the] sick list more and more often." (HU-CHURCH PROVIDER, Head of organisation).*

Then a specialist was engaged to lead sessions with a group of carers on a weekly basis, but the expense involved in running such sessions on an ongoing basis was prohibitive:

> *"The specialist gave them a lot of good advice and in some cases the need for individual case management came up as well. It was very useful but it was not cheap at all. I can't promise that we would make it frequent even if they would need it." (HU-CHURCH PROVIDER, Head of organisation).*

Thereafter, an 'open door policy' was instituted, such that carers could come to the head of the organisation at any time with problems (whether work-related or otherwise [e.g. financial]). This support was obviously appreciated by the carers, and was a positive factor in their job quality:

> *"The atmosphere is very important, because if I do not enjoy myself, the elderly people notice it and it hits back [...]" (HU-CHURCH PROVIDER, Carer).*

> *"If there are any conflicts with the elderly people you can turn to the management and they will help you. They defend you, they appreciate you. The management is for the employees." (HU-CHURCH PROVIDER, Carer).*

By adopting this strategy the employer played an important role in enriching intrinsic job quality.

As the example above suggests, financial constraints mean that affordability is a key consideration in any attempt to enhance job quality and worker well-being.

(3) Peer support through organisational champions

Another model of support for carers and their clients – importantly involving very limited additional financial costs to the organisation – involved incorporating an important element of training alongside organisational innovation.

UK-FAMILY PUBLIC in the UK is a fast-growing family-owned private care company providing publicly-funded care. The owner wanted to improve communication within the company as it continued to grow, recognising that she could no longer provide the same support herself to her staff as when the company was smaller. So, in essence, the impetus behind creating new 'organisational champion' roles revolved around supporting and empowering staff, enhancing their skills and helping them to work better as a team, while improving the quality of care provide to clients (Wright and Green, 2017a).

Although the idea of the owner, it is salient to note that it was informed by the company's involvement in the Skills for Care[84] initiative on 'skills around the person' – so illustrating the importance of engagement with external bodies in the case of a family firm in stimulating innovation. This particular Skills for Care initiative starts from an assumption that care workers all have their own skills, knowledge, experience and attributes which they bring with them to their work and also that person-centred approaches are vital in ensuring that care and support meets clients' individual needs and preferences.

At the time of the fieldwork 'Community Champion'[85] and 'Dignity Champion'[86] roles had been introduced, and there were plans to introduce further roles in the future. Rather than introducing a new layer of management (which would have been one solution for a fast-growing company in which the business owner was increasingly stretched), the 'organisation champion' roles were filled by well-respected carers who maintained their day-to-day care roles; (hence the strategy adopted did not result in any change in staffing levels, but did enhance communication within the company). Although the 'champions' were not paid more, the business owner saw the creation of the role as demonstrating her commitment to career development and the value she placed in her staff. In terms of social inclusion, the innovation aims to increase the attractiveness of care work as a career. It is hoped that this initiative will help make jobs more attractive as employees are encouraged and supported to develop specialisms, which in turn might lead to increased recruitment (including from non-traditional groups) and/or reduced turnover. The 'champions' themselves saw the added value they offered by the very fact that they were on the same 'level' as the carers:

> *„The girls do struggle sometimes. There are things that they want to talk about. They don't want to particularly go to the co-ordinator, they don't want to go to the manager. There needed to be a level person. They obviously found some comfort in me. I see a lot of the service users…I do think that people have found quite a comfort. Someone they can just go to when it's not a massive problem but it is something that they feel needs to be looked into." (Community Champion, UK-FAMILY PUBLIC).*

[84] Skills for Care is the strategic body for workforce development in adult social care in England.

[85] The 'Community Champion' is someone who carers can talk to about values and also raise issues and concerns with about their role, rather than "going to the boss" (i.e. the business owner).

[86] The 'Dignity Champion' role is linked to the ethos of person-centred care and is concerned with upholding the dignity of the client in relation to language used (e.g. not "Mr Smith suffers with dementia" but "Mr Smith lives with dementia") and the environment in which personal care is delivered (e.g. "closing curtains and shutting doors").

The organisational champions undertake industry training to become specialists, for example in dementia care. The champions cascade their knowledge throughout the organisation (and externally in the community). It is envisaged that his cascading of knowledge will result in a general upskilling of all employees. The emphasis on skills development was highlighted in more general terms by the business owner:

> *„We have to give people the skills, the knowledge, the understanding, the support that they need to deliver and do a good job. We can't blame people if they don't do a good job. It starts and stops with us. We've got to support people." (UK-FAMILY PUBLIC, Business owner).*

> *„I think it is kind of giving people the tools they need to move forward...Because care is a career and it is not easy and it is stressful...This is a hard job. We are never going to be able to pay you the money you deserve to be paid but what we can do is look after you, nurture you. Support them all in a way they generally do deserve to be supported in. That is what it's all about." (Business owner, UK-FAMILY PUBLIC).*

This emphasis on support was echoed by the Community Champion:

> *"It is trying to make them see that the job that they do is amazing. They are all amazing. Every member of staff that works for us is amazing...I think in any job you need to be shown that what you do, there is someone there to say thank you when you've done it." (Community Champion, UK-FAMILY PUBLIC).*

Hence, the emphasis is on providing support to carers in a manner which makes sense within the financial constraints faced by the organisation.

2.3.1.3 Collaborative working

Collaborative working between carers, health professionals and other service providers underlies holistic care provision and also has the potential to streamline the efficiency with which (limited) resources available are used. To a great extent collaborative working is inherent in the self-organised teams in the Netherlands outlined below in the sub-section on 'innovation in organisational models. Innovations in collaborative working can also be driven by statutory needs to provide care in a climate of financial constraints.

Close working with one local commissioning authority may be regarded as an innovation for UK-METRO PUBLIC in the UK, which is one of two main providers in the authority's commissioning area, which together provide over 50 per cent of publicly funded care provision in the local area. This close working was prompted, at least in part, by the local commissioning authority's desire to raise quality standards in the light of the balance of the weighting in the competition for contracts in the previous commissioning round being overwhelmingly towards cost rather quality (reflecting the huge financial pressures on the care sector) (Green and Wright, 2017). For the next commissioning round (for which the competition was already underway at the time of the fieldwork) the desire was to place more onus on quality – although price remains paramount:

> *"It was a really poor procurement [last time] because we were under so much cost pressure. In this procurement [i.e. the current procurement round that the commissioning authority was preparing for] for example we're going to be assessing bids on a weighting of 70 per cent price, and 30 per cent quality. I think when we started out the last time, there was a 60/40 split*

between price and quality but then there was again an unprecedented financial pressure, so we ended up assessing providers at 90 per cent on price and 10 per cent on quality." (Monitoring and Commissioning Officer, Local Commissioning Authority A, UK-METRO PUBLIC).

Also the local commissioning authority was seeking to work more closely with care providers and to encourage care providers (who ostensibly are competing for care contracts) to work more collaboratively with each other to drive up the standard of care delivery. Hence in the next commissioning round a decision had been taken to award smaller lots in more geographical sub-divisions of local commissioning area A, with bidders being restricted in the number of geographical sub-divisions (i.e. lots) that they can bid for. Such a strategy is designed to enable more diversity of provision (with more smaller providers being awarded contracts) and to encourage greater provision of linguistic (important in an ethnically diverse area) and other specialisms:

"We reserve the right to actually work with the providers through the procurement process to get them to shift around. [...] When we [are looking to] award the contracts, one of the things we're testing the providers on, is how well you lead on, how do you propose to work with other providers. There may be circumstances when a visit can't be covered by X agency and Y agency next door can pick up that visit, so it's about partnership working and collaboration with other providers." (Monitoring and Commissioning Officer, Local Commissioning Authority, UK-METRO PUBLIC).

These developments are indicative of a market characterised by increasing collaboration – between commissioner and provider and between care providers within a particular local commissioning area, as an attempt to raise quality standards in a stringent financial environment. For carers themselves, the hope was that the development of more collaborative ways of working would open up more opportunities for progression within care, and also into social work and nursing. However, the extent to which this materialises has yet to be seen.

2.3.1.4 Innovation in organisational models

Different organisational models in care are associated with less or more control for different functions. In tightly regulated and bureaucratic systems (as illustrated in Hungary by HU-SOCIAL INSTITUTION and HU-GOVERNMENTAL PROVIDER in particular, and also by publicly funded care provision in the UK in the cases of UK-FAMILY PUBLIC and UK-METRO PUBLIC delivering care on tightly defined contracts) involving delivery of publicly funded care, the scope for developing new/ innovative organisational models is limited. Rather the emphasis here is on small-scale and rather incremental innovation. By contrast the franchise structure of UK-FRANCHISE PRIVATE may itself be seen as innovative in the context of care, although it is notable that it operates in a less financially-constrained market. In this case the franchise model allows for local discretion with central support from a national office; (the company itself is international, but most support to franchises is on a national basis, albeit some local franchises try to learn from international experience). UK-FRANCHISE PRIVATE is a corporate business but each franchise is independently owned and operated. The franchisees get the benefit of a corporate feel and some degree of standardisation, but have the freedom to run the businesses the way they want to, providing they meet the franchisor's expectations. The commercial rationale for a franchise model is that it is possible to grow relatively quickly, with cash investment from franchisees and reduced management at national level (Wright and Green, 2017b).

The company made a financial decision that it could not operate under local authority block contracts[87]. Geared to the premium end of the care market, its business model is one of offering flexible packages to clients with private funding, with rates charged set by franchise owners and so varying by franchise. In general, particular emphasis is placed on matching the carer and client on character and interests, in order to deliver companionship-based care, as opposed to a primary focus on provision of personal care (albeit often some personal care is involved). The fact that there is no major reliance on public funding means that charge rates are higher than for public funded care, and this affords the company has greater discretion in its activities.

This local autonomy and flexibility is illustrated by practical initiatives – such as a Memory Café and a Lunch Club organised by one franchise – which are then showcased through the franchise network as examples of good practice. In terms of local variation in the case study franchises, UK-FRANCHISE PRIVATE Local Franchise 1 placed particular emphasis on dementia care for care workers. Local Franchise 2 had developed a relationship with a social housing provider which had built some 'extra care' accommodation with on-site services and delivered care within that complex. Since all clients were in one place there was no requirement for carers to drive between appointments (as was usually the case in the local franchise area), and so it had been possible to widen the usual recruitment pool in that particular local franchise area to non-drivers. The clients' care was publicly funded, which was different from UK-FRANCHISE PRIVATE's general model, but Local Franchise 2 had been keen to take advantage of a new opportunity. Another example of local discretion of a franchise model operating at the premium end of the market was recruitment of a Learning and Development Manager by Local Franchise 2 as an investment in a 'people management' function, drawing on workers' prior experience in other sectors.

In general UK-FRANCHISE PRIVATE had slightly more stringent recruitment criteria than other care companies and sought to hire carers deemed suitable for providing quality care at the premium end of the care market. Objectively many features of extrinsic job quality were similar to, or only marginally better than those experienced in other UK care companies. Given a general ethos that to deliver quality care it is important that workers do not work over long hours the capacity for carers to work very long hours to increase their earnings was curtailed.

Another example of organisational innovation is provided in the Netherlands by NL-HOME SUPPORT, where a home support function that was previously separate had been re-integrated into a broader care organisation (Oosting and Koene 2017). An associated innovation as part of the re-integration was the extension of the job of the home support worker beyond cleaning to include some 'social support' and a 'signalling' function – which in turn provided an opportunity for enhanced links with other parts of the broader organisation (as set out below). The signalling function involved the home support workers communicating issues they faced in their work environment at clients' homes, including the condition of the client, to a co-ordinating nurse at the organisation's headquarters. This signalling function enhances the connection with the rest of the care chain within the organisation and enables emerging issues to be spotted early, such that connections with other units of the organisation can be made quickly. The changing role of the home support worker results in a competitive advantage for NL-HOME SUPPORT:

[87] A 'block contract' is a fixed payment made to a provider to deliver a specific broadly-defined service. Block contracts give a degree of certainty in respect of continuity and consistency for contractors and providers. Generally competitive costings are an important determining factor in awarding of contracts.

> *"And that is the attractive aspect for an organisation like [NL-HOME SUPPORT], to look at how you can close the gaps between care, welfare and household support, how can you make some kind of arrangement of that? And then you become an attractive partner for health care insurers, the municipality that is the idea of a complete offering, which is something a cleaning company could never do." (Home support director, NL-HOME SUPPORT).*

Role expansion to include social support and a signalling function makes the job more rewarding for the home support worker. Initially home support workers received training to develop the interpersonal, communicative and alarming skills necessary for undertaking the signalling function. This was reported by home support workers as being "*very useful"* and there was enthusiasm for further training sessions and for the associated contact with their colleagues who they otherwise would not meet. However, the additional sessions were subsequently postponed because of lack of funding available. The ensuing situation is indicative of the pressures organisations in the area of home support are experiencing.

Especially in the area of low-skilled home support work has intensified, but the ability to provide organisational support to workers to deal with this is limited. In home support resources for organisational support are extremely limited due to cost pressures: budgets are squeezed, while with a shift to output-based requirements the job demands have become more ambiguous and more encompassing at the same time for those whose duties extend to duties beyond unskilled home support.[88] Home support workers indicate the challenges this poses to them in the execution of their work:

> *"You have to watch out that you do not get too involved in a person, because then he will completely rely on you. Mentally that is hard from time to time, how to deal with that. And I find little guidance in these situations. […] I then try to push him towards his children, because he has seven children so you would expect that they would think of him. But no, he completely relies on me. [And do you contact the coordinating nurse for that?] Yes, but if you call, you do not come through. Only in the morning but I work at that time, so then I send an e-mail. But sometimes it takes a couple of weeks before you get an answer. I find that unfortunate sometimes, that you do not really have a direct line to ask what I should do with this situation." (Home support worker, NL-HOME SUPPORT).*

The organisation recognises the bind that the workers are in. Workers need to involve and activate the client's informal care network more, but many workers find this difficult and end up doing the additional work in their own time:

> *"It has become more difficult, what you previously did for a client in three to four hours, you now have to do in two hours. […] On paper, it seems as if the tasks have disappeared but in practice they have not. They want everything to be soberer, but if you are busy at the client, you do not want to deliver half work, you'd rather do it well. […] It is a group of low educated people, with not very high salaries that in the end also often clean in their own time, because they want their work to be done well and fully." (Planner home support, NL-HOME SUPPORT).*

[88] In NL-HOME SUPPORT in the Netherlands there are two grades of workers: (1) HV1: unskilled home support; and (2) HV2: where the home support worker has to help the client organise basic elements of creating a 'clean and liveable home'.

For management and supervisors it is difficult to support these workers in their changing work environment due to the limited resources available for the activities themselves:

> *"Well, cleaning a house in two hours, I don't know, and I am not a stick-in-the-mud, but it would take me longer. And then you get stuck because the municipality says you have to shift the resources between the clients; one needs more and the other less. But that part of providing less hours at certain clients is of course very minimal, as people stay longer at home and therefore also struggle more. […] When I started, I thought the municipality would be open for negotiation to see how we can help the client, but that is something I have come back from. I found that very sad, but I have to say I had to make a shift in mind-set, otherwise I had better leave. […] Having as little costs as possible, is at the top of the list, or actually it is the framework in which I work. And we can do more with that, we are not done, but sometimes it is difficult. I can of course do more with [the Welfare division], I started making contacts there and to briefly walk in there every week." (Coordinating nurse, NL-HOME SUPPORT).*

With respect to the signalling training, home support workers clearly appreciated the training, but also noted that, with the additional pressure of the requirements to do less themselves and leave more to others (such as family members and neighbours) the training added to an already full work load. While the training provided them with the possibility to develop interpersonal and communication skills, as well as knowing when to raise the alarm, necessary for undertaking the signalling function, they acknowledged that:

> *"[The training] is definitely useful. Indeed, you learn a lot from it, it's just that, sometimes it is hard to apply it all in the short time you have, because the people do actually ask for a piece of your attention." (Home support worker, NL-HOME SUPPORT).*

So this example showcases an organisational innovation that has the potential to improve job quality for workers and to improve anticipation of changing care needs for clients, but which is being thwarted by lack of funding.

A final example of organisational innovation is provided by *geographically-based self-organised teams* in the Netherlands. With decentralisation of responsibilities for homecare from the national government to municipalities in the Netherlands, NL-HOME CARE has sought to rethink the organisation of homecare in general. The combination of increased cost pressures, a desire to enhance the client-focus of homecare, and a call for a re-appreciation of the professional role of home care professionals, have driven initiatives to introduce *geographically based self-organising teams*, embedded in the local community. One particular innovation is the development of self-organised teams. Of special interest from a job quality and employment outcome perspective is that such teams in NL-HOME CARE potentially offer greater possibilities for progression, with the district nurse playing a central role (Balhuizen and Koene 2017).

This innovation is top-down in nature, stimulated by the 'visible link' programmes of the Netherlands Organisation for Health Research and Development, so demonstrating the role of national institutional and support structures in innovation. Where relevant, unions and the works council were involved, but otherwise the innovation was management-driven, although employee participation in effective implementation of the new organisational structures was considered especially important.

Two key developments have been driving the general interest in self-organisation solutions in Dutch home care organisations. First the shifting policy emphasis: from efficient institutionalised care to widely shared,

more holistic client-oriented care solutions. Large homecare organisations had built up very large bureaucratic professional care organisations where work was done by professional nurses, nursing assistants and cleaners, who in the end provided quite costly and also rather impersonal care solutions. Discontent with the performance of these organisations increased the call for more widely shared community care solutions where home care professionals were expected (and allowed) to not only provide more client-oriented personalised care, but also aim to organise voluntary care around the patient relying on family and neighbors. The second development was the very successful introduction of geographically-based self-organising teams by Buurtzorg: a quickly growing and highly successful new Dutch homecare organisation, following an innovative organising model with a 'nurse-led model of holistic care' (Buurtzorg, 2017) which has attracted significant attention throughout the Netherlands and beyond.

NL-HOME CARE introduced the district nurse model in a cooperative effort with a regional health care association and five homecare organisations. Traditionally, district nurses fulfilled a central role in their neighbourhoods providing and helping people organise the support that they needed from cradle to grave. In the current model, the district nurse has again been positioned as key person in a neighbourhood care provision. (S)he fulfils a key role in the care network surrounding a client and acts as liaison between the care organisations, the clients and other relevant actors in the neighbourhood. NL-HOME CARE district nurses fulfil a dual role: first, they have an independent networking role, acting as visiting nurse and establishing the care requirements/ plans with individual clients bringing together the available expertise and possibilities for support around a specific client; secondly they are key actors – with coaching and co-ordinating roles – in NL-HOME CARE's self-organising nursing teams operating at neighbourhood level. These self-organising teams have around 10-15 team members, with the district nurse as 'team captain', acting as representative and contact person for the team, but leaving most of the discretion to team members in the execution of their work – as explained by the Manager of NL-HOME CARE using a footballing analogy:

> *"And on that playing field is a team captain. Who ensures that everyone in that field is connected to each other. But that captain also gets input from the sidelines, from the coach, from the trainers, from I know what, they get overviews, information, 'we notice this and that in the team, try to go a bit more this way or that way. Try to play more offensive or try playing more defensively.' And he then goes, with his own group to do it himself. But at a certain moment, as more safety arises in that playing field and people are better aligned, they need to do less." (Homecare Manager, NL-HOME CARE).*

For this relatively flat organisational team structure to operate effectively all team members require at least a specified skill level. In this instance, the minimum education level of team members was raised to Level 3 in Healthcare. Yet each team member has a specialism – for example, dementia care, palliative care, etc., to whom other team members can turn for assistance. Much of this support takes place virtually.

2.3.1.5 Raising the floor in extrinsic job quality

One means of improving extrinsic job quality is to improve minimum conditions of employment (i.e. to raise the floor in extrinsic job quality). Minimum wages are a classic example of such an attempt to 'raise the floor' at an economy-wide level.

In the Netherlands the *sector-wide collective agreement* for Nursing homes, care institutions and home care, maternity care and youth health care, negotiated at the national level by unions and care organisations, reflects such a measure (Keune and Koene, 2017). Besides *setting minimum conditions for employment*, the protocol with the 2016-2018 agreement highlights several points that the social partners

will pay special attention to in future: the need for reduction of the administrative burden and enforcement of the collective agreement in the sector; the continued monitoring of the bottlenecks that may arise as a result of the restrictions on the use of zero-hours contracts; the need to monitor working conditions and reduce increasing long-term sick leave; and the need for development and career perspectives to support sustained employability for employees in the sector. Social partners will also pay attention to increased employee involvement in decision-making around working times and working time scheduling. Furthermore, the protocol establishes the desire to fundamentally revise the collective agreement in due course to better adapt it to the development of industrial relations in the sector, the development of care in various sub-sectors, creating a balance between the employer and the individual employee in determining employment conditions, individual preferences of employees, and the role of works councils and unions. Finally, the 2016 protocol explicitly mentions the need for active attention to be paid to inclusion of employees with work-related disabilities, as their jobs have been relatively hard-hit when labour was cut during the period from 2014 to 2016 (SOVVT, 2016).

At sector level employment *charters* may be used as a mechanism to raise standards of employment. An example of this approach is provided from the UK by one local area in which UK-METRO PUBLIC operates having seen the introduction of new externally determined standards for the main contractors delivering homecare services. The *Ethical Care Charter* setting out these standards was developed by a trade union representing public service workers in 2012.

The objective of the Ethical Care Charter is to establish a baseline for the safety, quality and dignity of care by ensuring employment conditions that do not shortchange clients, and ensuring the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels. In so doing the Ethical Care Charter seeks to reverse the trend for councils (i.e. local commissioning bodies) to achieve savings in a 'race to the bottom': driving down pay and conditions, by setting minimum standards against which services are levelled up. Of particular relevance for extrinsic job quality are: first, payment for travel time and costs; secondly, that zero hours contracts should not be used routinely in place of permanent (guaranteed hours) contracts; and thirdly, payment of the voluntary Living Wage (as a minimum threshold). Details of the Ethical Care Charter agreed by local authority A are set out below.

1.	Time allocated will match the needs of clients (and will not be limited to 15 minutes)[89]
2.	There will be no minute-by-minute task-based commissioning
3.	Workers will be paid for their travel time (between calls)
4.	Both local authorities and service providers need to be transparent in their price setting
5.	Zero hour contracts will not be used in place of permanent contracts
6.	Local authorities will monitor service providers, including working conditions of staff
7.	Clients will be allocated the same homecare worker wherever possible
8.	Visits will be scheduled so that workers are not forced to leave to get to another client
9.	Homecare workers that are eligible must be paid statutory sick pay
10.	Homecare workers will be covered by the occupational sick pay scheme

[89] 15 minute care visits were used as a minimum by some providers.

11.	Providers will have a clear procedure for following up concerns about clients
12.	Homecare workers will be trained (and this will not cost them money)
13.	Homecare workers will be given time to meet coworkers to share best practice
14.	Homecare workers will be paid at least the (voluntary) Living Wage[90]

The payment of travel time and costs was seen as relatively uncontroversial at UK-METRO PUBLC (Green and Wright, 2017). The company had implemented this by building in an additional payment on top of the (voluntary) Living Wage that was equivalent to x minutes in every hour as travel time. However, take up of guaranteed hours had been low: any assumption that (most) staff would want guaranteed hours contracts had not been borne out. At the time of the fieldwork approximately 10 per cent of carers at UK-METRO PUBLIC had taken up the offer of guaranteed hours contracts. The Area Manager explained that she had realised a sizeable proportion of workers would not want guaranteed hours – on the grounds of prioritising their own flexibility (i.e. by letting the scheduler know either in advance, or immediately when the schedule for the forthcoming period was issued, that they would not be available to take up care appointments at certain times), but also admitted that guaranteed hours could have been difficult to operationalise for the company, given the nature of care work and when (throughout the course of the day) hours are needed. The Care Manager explained the pros and cons of guaranteed hours contracts vis-à-vis zero hours contracts as follows:

> *"The reason they choose not to do it and stay on their zero hours is because they lose their flexibility. So on a zero hours contract, they set their hours that they can work and they can change.[91] … The guaranteed hours contract is good because if you've got a lot of visits with a particular person and they're the majority of your hours for a week and that person goes into hospital or passes away, you're gonna lose those hours and there's not always something that we can give you in place of that until we get a new client so on the guaranteed hours contract, if that person passes away or goes into hospital, you're still going to get guaranteed to be paid the 30 hours a week that's on your contract so it's good in that way. But the problem is, is that a lot of the care workers have childcare issues so they need to change their hours around school times or child minders and those types of things so it doesn't suit everyone. I mean if you are a stable person that can do that, then it is good because like I say if you lose hours for whatever reason then you're gonna get guaranteed payment." (Care Manager, UK-METRO PUBLIC).*

The Care Co-Ordinator at UK-METRO PUBLIC who had previously worked as a carer on a zero hours contract but was on a guaranteed hours contract in her current role explained:

> *"I also liked the flexibility of it because of my kids. I could work at a certain time and leave at a certain time. [She also explained how she could attend school functions by altering her hours*

[90] If homecare workers are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract.

[91] So a carer might say to their employer than in general they are available on Monday, Wednesday and Thursday mornings, but then one week they might say that they are unavailable on a certain Monday morning, and so can they work on a Tuesday instead.

as necessary. She was on salary, rather than a zero hours contract, as Care Co-ordinator, and so would not have this same flexibility without taking holiday] The money side is good because I'm guaranteed that I will get paid whether I work or I don't work. As a carer you get more flexibility because you can choose your hours. I liked that." (Care Co-ordinator, UK-METRO PUBLIC).

The fact that there is a continuing demand for care work and a shortfall in supply of carers meant that most on zero hours contracts generally could work the hours they wanted. The relatively low take-up of guaranteed hours contract had led the commissioner to change the relevant key performance indicator on percentage of workers on guaranteed hours contracts:

"We've changed our key performance indicator to say how many of your workers have been offered the guaranteed hours contracts." (Commissioning and Contract Monitoring Officer, Local Authority, UK-METRO PUBLIC).

As a result of the imposition of the voluntary living wage the wage level increased – so attracting more recruits, including more males (who tend to form only a small proportion of the total workforce in care). Hence, raising the floor appears to be widening the pool of potential recruits, so making care more socially inclusive.

"We think it [the increase in male care workers] is because of the increase in salary. I think people understand that they can actually earn a living from it [i.e. care work] now. So, for example, if a male comes in, he can support his family now in [local authority A]. But I think in general terms the attitude towards males providing care has changed a lot as well." (Area Manager, UK-METRO PUBLIC).

In the case of UK-METRO PUBLIC, at the time of the fieldwork males comprised 5-10 per cent of the workforce. However, it was felt that for males more so than for females, care was seen as a pathway into other health professions:

"Domiciliary care is often a pathway into other health professions for males and I think it's where they start. So they'll start with us and then they might move into nursing or move into residential management so it's a stepping stone in their career rather than something they'll stick with for life. [...] [For women] that's where they [i.e. in a care worker role] and that's where they stay." (Area Manager, UK-METRO PUBLIC).

The pay rate is a further key factor in explaining variations in the number of applicants between different branches of UK-METRO PUBLIC. As noted above pay rates vary by borough, so in local authority A (where an ethical care charter is in place), the Area Manager described a situation of *"no recruitment issues"*. However, the Area Manager went on to qualify this statement that the higher hourly wage making care "*attractive to people [with no formal qualifications] as a method of earning money*" posed its own difficulties in terms of recruitment:

"You don't have to have experience, you don't have to have a background in care. The difficulty is that people now are aware of the fact this is a career that they can move into that pays £10.98 an hour and they don't have to have any qualifications or background in it whatsoever. So every man and his dog walks through that door." (Area Manager, UK-METRO PUBLIC).

> *"Recruitment's not a problem. We have a lot applicants because we have a high pay rate so there's a lot of applicants coming through. Retention is a problem. … People come because of the money and when they actually see what they need to do some don't stay because they don't want to do it. So some will do a day's work and then that's it. They say it's not for them." (Care Manager, UK-METRO PUBLIC).*

However, with more recruits coming forward in local authority A than elsewhere in this particular local commissioning area UK-METRO PUBLIC could be more demanding in terms of expectations about standards of performance because of the ease of finding new recruits, whereas elsewhere it was necessary to keep in mind the difficulties in replacing staff who left:

> *"When you're commanding a rate of £10.98 and you're getting a lot of recruitment through you have more control over the people that you're working for because you have the choice. … If their performance isn't up to scratch, you can say your performance isn't up to scratch, we're paying you this amount of money, this is what we expect. When you're paying £8 an hour, your expectations are naturally a little bit lower." (Area Manager, UK-METRO PUBLIC).*

2.3.2 Technological innovations

To a great extent financial pressures limited technological innovation in the case study companies. In Hungary and the UK affordability of technology when delivering for public sector (i.e. local authority/municipality) contracts was a key barrier to adoption:

> *"Local authorities are very unlikely to support you [with mobile technology] so it is difficult to afford. It is difficult for companies to invest in technology because margins are very tight." (Director of Policy and Communications, UK-METRO PUBLIC).*

The case studies also revealed strongly held views about whether, and what place, technology should have in care. Some case study companies were at pains to emphasise that they were fundamentally 'care companies' and not 'technology-based companies' and this limited the role of technology in their operations:

> *"Technology for us is more in terms of our ability to control our workforce in terms of auditing where they are, what they are doing, and their safety. … What happens is that when a caregiver arrives at a call, the call is scheduled into an electronic system, they use the client's telephone, not a mobile, which doesn't cost the client anything, they ring and put a code in, and we know they've arrived safely at the client's house. If they're not there within a certain amount of minutes, an alarm goes off on our mobile telephone, and we can also see it on the TV. This gives us the ability to call the client, or call the caregiver, and say, 'Where are you?'" (Managing Director Local Franchise 1, UK-FRANCHISE PRIVATE).*

This illustrates a role for technology in administration; whereas its role in care delivery needed to be clearly defined. The sentiment of several interviewees was summed up as follows:

> *"There is going to be a growing opportunity for technology to become part of care but it cannot – and should never – replace the human contact." (Co-owner, Local Franchise 2, UK-FRANCHISE PRIVATE).*

2.3.2.1 Digital tools for planning, monitoring and reporting care provision

For the most part technological innovations highlighted in the case studies involved use of digital technologies. A recurring theme in the case study interviews was recognition of the role of information and communication technologies (ICT) in facilitating planning, reporting and delivery of care, but often limited levels of implementation, with lack of finance being a key constraining factor, as outlined at the start of this section. The role of digitalisation for administrative functions was widely recognised, especially given the care is "*fundamentally a logistics business*" (Director of Policy and Communications, UK-METRO PUBLIC). Another issue raised was lack of familiarity of clients, and of some carers, with ICT. In general, use of ICT was more advanced in administrative reporting of care, than in care delivery itself – with regulation and financial and other reporting were key drivers in care administration.

In Hungary in the case of HU-CHURCH PROVIDER a bespoke unified documentation system had been introduced by the management in the previous year in order to reduce the administrative burden of all concerned in planning and delivering care; (this had been financed through organisational savings yielded by the operation of the new system). The software behind the system was multi-purpose, and involved linking clients' documentation, carers' activities, financial reporting (to the state) and calculation of care fees for clients. It continues to be modified to enhance its usability. The system was used to prepare a weekly schedule for carers, with the clients also having to sign regarding care received (although it was reported that in reality the carers often complete and check the documentation at home in the evenings). Hence the innovation had not necessarily improved job quality for carers although there were advantages for the provider (Patyán et al. 2017a).

Similarly, in the UK the Care Manager at UK-METRO PUBLIC described how the introduction of a software package (at the instigation of the Group head office) to monitor compliance had brought advantages to the company (Green and Wright, 2017). When she had joined the company records were paper-based. In particular, the new system had been useful for flagging up when a client's care plan was about to expire or when a carer's passport expired (the latter being a crucial issue given substantial numbers of non-UK citizens employed). The system had also been used to flag up when quality visits were needed. This had helped streamline planning and had had a positive impact on the job quality of the Care Manager and Care Co-ordinator, but had not had any implications for the day-to-day work of the carers.

At the time of the fieldwork UK-FAMILY PUBLIC had looked into shifting from a paper-based to a digitalised system for rostering and care plans (Wright and Green, 2017a). With the paper-based system weekly rosters were printed out and staff came into the office to pick them up. When arriving at a client's home, staff used the client's telephone to let the company know that they have arrived (i.e. check in). At the end of each home visit, the carer wrote notes by hand into the client's care plans. Every month, the notes from each care plan were brought into head office for collation and review. Under a digitalised system, care plans will be recorded live, via an app which will be installed on every carer's smart phone. Carers will check in and check out of clients houses so at any given point in time the company will know where every carer is. If a carer fails to check-in to a call, then the system will alert the office to say that the carer has not arrived.[92] Moreover, the entire recording and monitoring of individual care plans will be digitalised.

Two main reasons were cited for considering adoption of such technological innovation. First, the local commissioning authority had an expectation that all contracted care providers have electronic monitoring

[92] The carers are used to specific time allocations for each call and of the need to keep to times allocated to complete rostered calls within a particular shift, so no concerns were raised in interviews regarding 'surveillance'.

systems in place, (so illustrating the importance of commissioners and regulators in driving innovation). Secondly, after the initial migration of data over to the new system, the company will have real time access to details on the care that has been delivered to all of its clients and the staff involved in delivering this care. At any time, after necessary permissions have been granted, family members will be able to view details of the care that has been provided to their relative. So this innovation has the potential to improve communication channels between the care company, clients and their families.

When the owner first considered moving to the new digitalised system, implementation proved too difficult, so it was delayed. Shifting across to the new system would have been very time consuming because it was not possible to migrate details from the existing care plans over into the new system automatically. Rather, details from each care plan would have had to have been re-entered into the new system. During this time, the company was busy with implementing the local commissioning authority's new block contracts and so they did not have the necessary time required to embark on implementation of this technological innovation. This is indicative of care companies being consumed by dealing with the 'here and now' of care delivery, so limiting time available to devote to strategic investments. Originally, the owner also had a number of concerns about data security, which have since been allayed. So a decision was made to delay introduction of the new technology until a later date.

Since initially delaying implementation, the company had changed some of the ways they work. In particular, introduction of the new technology aligns with a shift away from task-focused to outcome-focused care plans, and this will ease migration of care plans over to the new system. In addition, functionality of the app itself has been improved. At the time of the fieldwork UK-FAMILY PUBLIC was about to trial the new system in the largest town it operates in.

Shifting to digitalised care plans is expected to make rostering and monitoring more efficient. Whether this will directly lead to a change to employment levels or structures was not clear. However, the introduction of digitalisation has implications for the work routines of carers, given the shift from handwritten notes to using their smart phone to record details of what they did during their visits. In addition, rather than staff coming into the office to collect their rota, all details will be displayed via an app on their smart phone. Family members of the clients, where they have been given permission, can also log into the app to check on the care that has been delivered and whether there is any other information that they need to know. On the one hand, entering details via the app may limit discretion and autonomy; as one carer noted:

> *"I am a pen and person paper. I would prefer to sit. I think the thing with sitting and writing is that it is personal. It shows you've sat down and thought about what it is that you are writing. Whereas this app, the tasks are going to be there and you just tick what you've done." (Carer, UK-FAMILY PUBLIC).*

On the other hand, it may mean that the carers will have more time to actually care for their clients; resulting in a more rewarding or fulfilling job:

> *"I think we had two people that were not keen on using their own phones; they were an older two members of staff. … It's getting over to them it is going to be easier than writing a text and it's going to save them time. Just a little bit more support - for the people that aren't totally happy to use it straight away, come in here, run through the app, providing extra support. Get everyone happy to use it. It was designed by somebody that owns a care agency. So it was designed by somebody that knows about the issues." (Owner, UK-FAMILY PUBLIC).*

Clicking on tasks rather than having to hand write notes may mean care work is more inclusive of migrant workers. A UK interviewee from UK-FRANCHISE PRIVATE (Wright and Green, 2017b) expressed concerns about technology in this regard:

> *"One of the things that I'm cautious about with technology - and in fact I've got someone who's working on a technological package at the moment - but…some of the stuff I see particularly in care homes, in residential settings, is horrendous. I have a contact who has developed and is continuing to develop a thing for care homes. […] He's found a niche in care homes, because people's command of English is so poor, because they're from a workforce that's not expected to speak or to have any command of English, and yet they are looking after people with dementia. They have now a system whereby the carer goes in to see the client in her or his room, does their tasks, and then on the keypad on the way out there is a series of pictures: smiley face, flat face, whatever. You press smiley face. Then it has a picture of food, so you press food, and then wash, bath, shower, medication. And this thing [which is automated] then prints out the care log in the care manager's office, which you can show the CQC [Care Quality Commission[93]]. And on there it says, "This morning I went to see Mrs So-and-So. When I went into her room I found her to be calm, happy, whatever." […] I gave her breakfast, because it was that time of day, and I then washed her, and gave her her standard medication. When I left her, she was still calm, happy, and whatever." (Manager, Local Franchise 1, UK-FRANCHISE PRIVATE).*

Local Franchise 1 at UK-FRANCHISE PRIVATE had moved to a new digitalised care planning system. The former "*horrendous*" scheduling system was at capacity, but with the new system it had been able to grow the business:

> *"We've actually been able to grow the business quite dramatically because of the system. Because previous to that it was almost impossible to plan for any more hours than we were already planning for. Whereas now we've been able to increase by another 400 hours than what was previously being planned for." (Recruitment/ Care Co-ordinator Local Franchise 1, UK-FRANCHISE PRIVATE).*

The new system also enabled other features that enabled rostering, such as an ability for a 'block' to be put on hours of work for an individual carer who might wish to set a particular ceiling on hours worked per week.

2.3.2.2 Geographic information systems (GIS)

A related innovation is use of GIS in care planning. UK-FRANCHISE PRIVATE used GIS and geodemographics based on consumer data, census data and business analytics to delimit franchise areas, dividing the UK territory into franchise areas with a minimum population of 25 thousand people aged over 65 years.

There is scope also for using GIS to plan care schedules. It makes sense to put care visits together in a sensible geographic way to reduce travel time and to enable carers to better utilise their time. To some extent there was acknowledgement that care workers have always acted autonomously and have adjusted their schedules so that they work better in this regard. However, a problem arises if this is not

[93] The social care regulator.

communicated to the care co-ordinator; as there is a need to ensure that clients are not pressurised into accepting unsuitable call times.

An example of use of GIS in planning care rounds is provided by the Care Co-ordinator at UK-METRO PUBLIC. When she took up her post relatively recently she knew the local area very well and found that several carers were travelling some distance to deliver care. She tried to roster carers to deliver care close to where they lived. She initially used her local knowledge to do this and then described how she would extend this by googling the carers' and clients' postcodes when she was at home to see how far apart they lived and how long it would take them to get there. She then devised call plans such that carers could walk between calls in 15 minutes (something that is possible in a densely populated metropolitan area). This had since been 'templated' on the People Planner system.[94] As a result "*we don't have so many people dropping calls or running late"* – so bringing advantages to the company and to the carers (Green and Wright, 2017).

2.3.2.3 Video-calling

As emphasised above, many of the case study interviewees (across all case studies) emphasised the personal nature of care. In the Netherlands at NL-HOME CARE the introduction of video-calling for clients who needed minimal supervision (e.g. just a check up to see that all is well) or physical support had been introduced as a substitute for physical travel, especially convenient for the rural areas where it also provided its services and travel time between clients was significant, so providing flexibility for workers and freeing up time for other activities (Balhuizen and Koene 2017). In other instances where previously two people had needed to be present to administer medication, video-conferencing eliminated the need for the physical presence of one worker, with a second pair of eyes joining virtually.

> *"And what we do with this is that a number of people from home …, contact a number of clients, just talk to each other by means of video-calling every day. And who calls in with a client and that can range from just a chat to 'have you have already taken your medication?' and that these people can also show they did. This way you are also in contact with your clients….you've lost much less travel time and people are also much more free in their comings and goings, because they do not necessarily have to wait for that neighbourhood sister because you can just call and then you're done." (Manager, NL-HOME CARE).*

From an organisational perspective video-conferencing brings greater efficiency to the organisation while also providing opportunities for enabling more frequent contact by less qualified staff:

> *"For example, we do video-calling. I was responsible for the project. 70 hours a week we provide our care through video-calling, rather than through a personal visit. So, so we connect with the iPad, with a customer and let him take his medicine via the screen. This is an example. That's a big time saver, driving up and down ... Yes, furthermore, that video-call can also be done by somebody from our welfare department, why not?" (Team Leader, NL-HOME CARE).*

Hence, ceteris paribus the introduction of video-calling opened up opportunities for inclusion of less skilled workers, promoting labour efficiency and freeing up hours of scarce skilled staff.

[94] See https://www.theaccessgroup.com/homecare/features/ - this is a cloud-based real-time care monitoring and planning system, also providing HR, finance and other functions.

2.3.2.4 Medical Box

A related innovation is the Medido (Medical Box) mentioned as a technical innovation by care workers in NL-HOME CARE. The Medido is a package that is dispensed by the pharmacy and brings the patient's medication together in one place, already pre-checked and sorted by part of the day. When the patient is due to take medication, the box makes a beeping sound, which continues until after the medication is taken from the box. If this does not happen; a signal is sent to either the pharmacy or the district team who then check to see if something is wrong and then make sure that the medication is taken at the right time. Where videoconferencing can substitute the second professional that needs to be present during the performance of certain medical proceedings, in the specific case of checking the medication type and dosage, the Baxter roll fulfils this role of second observer. As the contents are checked at the packaging point it is not necessary to do this at the time of intake.

On the one hand use of the Medical Box makes the work of the nursing staff less time-demanding while still fulfilling their control activities with patients. It offers the workers more flexibility. However, it also leads to work intensification as simple and easy tasks are removed from the work of the nurse-carer.

2.3.2.5 Electric bicycles

An exception to digitalisation and related technologies in technological innovation was the introduction of *electric bicycles* in Hungary at HU-SOCIAL INSTITUTION (Tróbert et al., 2017). Here the previous director had introduced the *electric bicycle* (with financial support from abroad) as a means of improving working conditions. The aim was to make work easier, as the carers cover considerable distances in the town in the course of a working day. However, in this top-down innovation the opinions of the cares were not considered. Their use is tiring – the bicycle itself is heavy and it is very difficult to use them on uneven surfaces. Many carers found riding in public road traffic very stressful and they are also exposed to extremes of the weather (rain, snow, ice, etc.). Often it is difficult to carry the equipment needed on the bicycles. Finally, since use of the bicycle is not compulsory, the carer who does use it cares for more clients and the uneven distribution of workloads can cause tensions among the carers. All of these unanticipated problems highlight the importance of employees' involvement in both the design and implementation process of innovations. Furthermore, maintenance of the bicycles proved a significant problem: servicing and the replacement of batteries is costly and there are no funds to cover these expenses. Hence this innovation is unsustainable in current financial circumstances.

2.3.2.6 Summary

In summary, the case study examples outlined above indicate that technological innovations seem to have multiple effects. They ease administration and facilitate planning. In cases such as smarter scheduling, video-calling and the Medical Box, they can be seen as decreasing work pressure and enhancing efficiency. Such innovations can mean that job quality is also improved as work becomes more interesting and challenging. At the same time, such developments can be seen as raising the required skills levels in a sector facing ongoing recruitment difficulties despite limited barriers to entry and where wage levels are relatively low. Increased demands from technology may mean that social care becomes less inclusive in terms of the employment opportunities it offers, albeit in Hungary and the Netherlands a division between 'domestic help' and 'personal care' roles is indicative of greater segmentation within traditional 'carer' roles. It is also the case that technological demands may lead to work intensification as some simpler and easier tasks are removed from the work of the carers.

3 Inter-relationships between innovation, job quality and employment

Moving away from the detail of specific innovations, this section is concerned with cross-cutting issues across all of the case studies.

3.1 Impact of innovations on job quality

Commencing with consideration of the *impact of innovations on job quality*, it is clear that funding pressures mean that innovation has little if any influence on *wages*. For the majority of carers wages are determined by the national minimum wage (in Hungary and the UK) and by sectorial collective agreements (in the Netherlands). One exception to this is the Ethical Care Charter in the UK (an innovation in itself adopted by a care commissioner) which raises the wage floor to the voluntary living wage (which is higher than the national minimum wage). Extra responsibilities stemming from innovations tend not to be translated into higher wages; rather there is a greater emphasis on non-wage benefits (such as social events and trips) which provide opportunities for lone workers to come together. Moreover, there appeared to be general acceptance of the fact that 'there is no money available' amongst the workers interviewed in the case studies.

Similarly *employment conditions* tend to reflect national minimum standards, with innovation playing only a limited role in identifiable extrinsic improvements. In Hungary public employees who become full-time employees tend to significantly improve their labour market position. In the Netherlands, organisational innovations and especially developments around self-organisation have significantly affected the working conditions of skilled care workers. For the relatively unskilled domestic help workers there has been little to no innovation with equally limited impact on employment conditions.

In those (few) locations in the UK where the Ethical Care Charter is in operation workers have the right to move from zero hours to guaranteed hours contracts (albeit take up is low). Opportunities for internal progression vary between roles; in Hungary and the Netherlands there is some evidence for progression from home support to care roles.

Given the limited scope to increase wages or improve employment conditions markedly, innovation efforts tend to be focused on ameliorating working conditions. In Hungary, HU-CHURCH PROVIDER introduced innovations to measure stress and burn out and took action to improve workers' self-esteem. Likewise in the UK attempts to better 'match' carers and clients in terms of their interests and so increase the chances of a positive relationship (at UK-FRANCHISE PRIVATE) was done partly to improve (intrinsic) working conditions of carers (as well as being motivated by improvements to care provided. In a similar vein use of GIS to enhance scheduling of visits and reduce travel times has served to reduce the burden of travel time. The move away from a 'time and task' model of care delivery to a greater focus on 'outcomes' has served to enhance the variety of tasks for workers and so increased their autonomy. However, greater autonomy can spawn additional organisational tasks and increased work pressure, especially where support available to workers is inadequate. However, innovations have not uniformly resulted in greater autonomy for workers: in Hungary in the case of HU-GOVERNMENTAL PROVIDER organisational restructuring resulted in greater bureaucracy which in turn reduced worker's autonomy (Patyán et al., 2017b).

In general *trade unions* have played a limited role in encouraging innovations to improve job quality. However, there have been innovations designed to increase employee voice, albeit on an informal rather than a formal basis. In time such structures have the potential to stimulate small-scale innovations.

Likewise innovations have had a limited role in improving *work-life balance*. The nature of care itself means that it is necessary to respond to crises, which can occur at any time. At the same time the increasing need for care, falling budgets and growing labour market shortages increase work pressure for individual workers in the sector. Internal support mechanisms (notably involving peer-to-peer support) help in providing a route for workers to offload work-related concerns about some of the more challenging aspects of their jobs, rather than taking difficulties home with them. Education and training support (e.g. bereavement training) can also help in this respect. The fact that an innovation assuring a right to move off zero hours to guaranteed hours contracts had low take up demonstrates how some workers place value on ongoing flexibility for work-life balance, as opposed to following a route which in objective terms might seem to offer more predictable working patterns.

Innovation is often accompanied by *education and training.* This is particularly evident in the case of the geographically-based self-organised teams in the Netherlands. Here there were many opportunities to upskill the employees and so develop the team as a whole. In some instances a circular relationship is evident: in the case of *UK-Franchise* one local franchise's innovative attitude to encouraging education and training was specifically designed to empower employees, perhaps resulting in a fostering of innovation (and enhanced job quality). In the case of NL-HOME CARE training to support an innovation (i.e. the 'signalling' function of home support workers) helped to motivate the workers and helped them feel that their role was recognised, but subsequent cancelling of training due to budget cuts had the opposite effect. It highlighted the dominant cost pressures in low-skilled care work, which limit attention for education and training (Balhuizen and Koene, 2017).

Support for workers associated with innovations tends to enhance *job satisfaction and self-evaluated job quality*. This was certainly the case in Hungary at HU-CHURCH PROVIDER, where innovation was directed at providing greater support for workers. For many carers job quality is intrinsically relatively high and this is a function of motivation and pride in their dealings with clients, rather than being associated directly with innovations per se.

3.2 Impact of innovations on employment levels, skills structure and inclusiveness

Innovations have had limited impact on *employment levels* in social care; rather employment levels are dictated primarily by the (growing) elderly population in need of care and factors at macro level such as funding available. A strong belief from several case study interviewees that technology cannot substitute for the 'human touch' suggests a limited appetite for technological innovation to substitute for workers in delivering care.

Innovations tend to have more impact on *skills structure* – on balance, the overall direction of travel has been for innovation to increase skill demands on staff, especially through greater multi-skilling (although there are some counter examples). This is particularly apparent in the case of the geographically-based self-organised teams in the Netherlands at NL-HOME CARE, where social innovation (i.e. self-organised teams) increases skills requirements, and where associated technical innovations also require upskilling. A simpler example is the case of 'narrative reporting' in the UK at UK-METRO PUBLIC, which requires a higher level of English language reporting skills than was formerly the case. On the other hand use of menu-driven apps requires rests more on use of pictures than of words, so placing fewer demands on literacy.

Innovations have had little if any direct impact on the *gender* structure of the overwhelmingly female workforce. This is also the case for the *age* structure of the workforce and the proportion of *migrant*

workers/non-nationals employed. To some extent the fact that innovation has stimulated a requirement for more complex skills sets there is a potential danger of excluding the *less skilled* from the workforce, but there is little evidence on this to date.

3.3 Impact of job quality and employment on innovations

Evidence from the Netherlands suggests that skilled, experienced and relatively entrepreneurial individuals are needed to establish and successfully run self-organised teams. Typically workers in care have relatively low qualification levels, and this in itself can act as a brake on innovation.

Trades unions and works councils (where they exist) have had a limited impact, if any, on innovations. In Hungary in the case of HU-GOVERNMENTAL PROVIDER the public servant's council opposed the implementation of innovation but this had no impact (Patyán et al., 2017b). With the exception of trade union initiated Ethical Care Charter, it has been management, rather than workers or their representatives, that has been more important as a driving force for innovation.

In most of the cases studied, with the exception of HU-GOVERNMENTAL PROVIDER where a bureaucratic organisational culture dominated, the management were open to *employee suggestions for improvements*, and had put in place mechanisms (even if relatively embryonic) to stimulate this. To date, however, the role of employees' suggestions on innovation had been limited. The *intrinsic interests of employees (and managers) in improving the quality of care provided* can act as a positive resource for innovation, albeit this was not always apparent in practice – partly because their energy can be (almost entirely) expended in performing their current roles and also because of a lack of experience in taking the initiative in a wider work environment and a shortfall in resources. Indeed, a key motivation for becoming a carer/working in the sector for many of the individuals interviewed in the case studies was to improve the quality of care, so this is likely to predispose them to consider favourably innovations that improve the quality of care - even if this does not seem to result in higher extrinsic job quality (as in the case of the organisational champions in the UK at UK-FAMILY PUBLIC). This is illustrated by the fact that in the Netherlands the primary care team was the main driver of any improvements or changes that were implemented by self-organised teams in the Netherlands at NL-HOME CARE, while in NL-HOME SUPPORT a training programme to support workers to undertaken a 'signalling' role in recognising actual and emerging care needs of clients was appreciated. The Dutch cases also show how the professional disposition of the care workers and the personal responsibility that home support workers feel in the relationship with their clients is the Achilles'-heel for professional care workers. The growing professional discretion and responsibility coupled with cost-reductions and the growing demands on the sector lead to situations where job quality is actually threatened due to increasing work pressure and work intensification.

3.4 Other interlinkages and impacts

In most instances the empirical evidence from case studies suggests a relatively limited role in practice for *interlinkages between technological and organisational innovations*: technological and organisational innovations occurred largely independently of each other. In part this reflects a lack of funding for technological innovation. A partial exception is provided by the use of GIS to help define carers' schedules. A fuller exception is the example of the self-organised teams in the Netherlands at NL-HOME CARE, where the use of technological innovations has enriched the work of homecare nurses and made them more

efficient, but for the benefits to be reaped there is a requirement for more highly trained personnel and training of existing staff.

The openness of, and resources available to, *management* plays a crucial role in innovation. In UK-FAMILY PUBLIC – a family-owned company – theoretically the manager exercised a good deal of discretion with regard to implementation of innovations, but in practice action was curtailed by a harsh funding environment curtailing the sphere of action. Also in the UK at UK-FRANCHISE PRIVATE – where local franchises had central support – and operations were (almost entirely) in the privately-funded care market, there was greater scope with regard for innovation. The example of UK-METRO PUBLIC – a company running under its own name as part of a wider group delivering publicly-funded care, suggests that it is care commissioners, as opposed to managers, who are the most powerful actors in setting the context in the publicly funded care market in the UK. The evidence from Hungary and the Netherlands points to limited room for manoeuvre for management in the face of financial constraints.

Budgets/financing arrangements emerge as the dominant factor on the job quality-innovation nexus. On the basis of the case study evidence the impact of funding in curtailing innovation and imposing a ceiling on improving job quality is the dominant factor, summarised for each case study as follows:

HU-SOCIAL INSTITUTION	The organisation is operating under constant financial instability, therefore even the tiniest innovation is considered to be too costly. (This is an example of a low road nexus of innovation and job quality [i.e. no innovation, poor job quality]).
HU-CHURCH PROVIDER	The organisation is maintained by a church ensuring a slightly better financial condition than in the other two cases in Hungary. These limited extra opportunities are exploited by an active, creative and employee-orientated management. It would be an exaggeration to call this a 'high road' job quality-innovation nexus, but these two mutually reinforce each other providing much better job quality and much more innovation than was observed in the case of the other two organisations in Hungary.
HU-GOVERN-MENTAL PROVIDER	Poor financial situation is a prime reason for the bad job quality-low innovation nexus.
NL-HOME CARE	Public sector, budgets are a dominant factor. Activities are structured following the financing structures dictated by the insurance companies and municipality level agreements.
NL-HOME SUPPORT	Cost pressure is a very limiting factor.
UK-FAMILY PUBLIC	Financing arrangements (i.e. the money available for care at national level) is of key importance in impacting on job quality an innovation, given the reliance of a (publicly funded) block contract. Severe financial constraints limit scope for action on extrinsic aspects of job quality and financial resources for innovation.
UK-FRANCHISE PRIVATE	The fact that the franchise operates in the privately funded care market means that financial pressures (although important) are less severe than for companies operating in the publicly-funded care market. The franchise model offers opportunities for learning (between franchises and internationally) regarding job quality and innovation.
UK-METRO PUBLIC	Financial pressures on the care sector nationally are a dominant factor in limiting scope for improvements in job quality and also innovation. At local area level differences in monies available from different local commissioning bodies means that scope for extrinsic improvement in job quality (and to some extent innovation) varies between local areas.

4 Conclusions

The context for consideration of the innovation, job quality and employment nexus in the care sector is one of greater demand for care in the context of an ageing population and more complex care needs, with an increasing emphasis on client-focused care at home. These trends along with harsh budgetary constraints have led to a need for greater collaboration between care providers and also with other stakeholders in the wider health, social support and related spheres. National legislative and regulatory changes also impact on care organisations, with ongoing reforms meaning that they have to operate within a complex and fast changing policy environment. All of these are drivers of change.

Care workers face a high workload with generally increasing demands. There is a need for a re-appreciation of the role of care workers and associated professionals. Education and training programmes and some associated support structures recognise this and a positive development would be for to build further on good practice in this regard. However, as re-emphasised below, stringent budgetary constraints limit the scope for radical action or for increases in pay. Many care organisations face labour shortages and ongoing recruitment and retention problems. Factors indicative of poor extrinsic job quality, notable relatively low pay and the often physically and emotionally demanding nature of care work are factors here. However, the relatively low barriers to entry (for home support and carer roles without nursing elements) mean that this is an inclusive sector – offering opportunities for job entry to those with no/low qualifications even in slack local labour markets.

From a positive viewpoint the case studies and wider literature reveal examples of organisational innovations such as geographically-based self-managed teams in the Netherlands which seek to provide holistic care embedded in the local community. The example of the organisational champions within the UK operate in the same direction to give workers voice and promote some enhanced discretion within their job roles, while providing them with peer support while incurring little, if any, extra costs for the organisation. Likewise education and training initiatives seek to enhance their skills sets – including to deal with a greater proportion of clients living with more complex and challenging conditions than had formerly been the case as provision of care services has become ever more focused on more needy clients. In general, these types of organisational innovations serve to enhance job quality for workers while also having a positive impact on clients. However, the fact that such initiatives are operating in a context of cost-reductions and growing demands in the sector lead to work intensification, which in turn compromises job quality. The case studies also showed cases of education and training programmes and support mechanism that were valued by organisations and workers alike being curtailed in the face of funding constraints. A policy desire for more collaborative working, requiring enhanced management and negotiating skills can break down when (nearly) all individuals and organisations concerned are under financial pressure and are having to prioritise/ration what they do to meet their own individual/organisational needs.

For a positive dynamic to exist between job quality and person centred care workers need to have the necessary training to perform their tasks and also to have the skills to 'set boundaries' regarding what is part of their job role and what is outside it and to negotiate with others accordingly. They also need to prioritise tasks within their job role as to which are most important. This is necessary to avoid work spilling over into the non-work domain. However to some extent this curtailment of work tasks which can be necessary to maintain work-life balance and avoid burnout runs counter to what lies at the heart of their intrinsic job quality: pride in doing a good job in caring for their clients and developing and growing a good and mutually appreciative relationship with them.

Much of the technological innovation highlighted in the case studies has focused on enhancing the efficiency of administrative functions, such as scheduling and rostering, monitoring of care visits, ensuring regulatory requirements are dealt with and invoicing. In general such innovations have been positive in terms of organisational efficiency and helping business growth. Use of GIS-type software for planning can help in planning more efficient routing and allocation of care visits, so reducing travel time. On balance this is positive for care workers. Other technological innovations have enabled more care functions to come within the ambit of care workers, so leading to increased complexity of work and enhanced skill requirements. On the one hand this may lead to greater job satisfaction, while on the other hand making job roles more complex – which in turn may lead to greater segmentation within traditional carer roles.

Most of the innovations detailed above are 'top down' innovations, often driven by regulatory and/or financial imperatives. This suggests that external drivers are important in triggering innovation that does take place. While some care organisations have sought to take more account of the voice of carers and other home support staff – who are in effect often those closest to the clients and who are in a position to 'signal' to others within the health and care system changing client needs – such mechanisms are often relatively poorly developed (although there are exceptions, as the case of NL-HOME SUPPORT illustrates) and relatively low-skilled workers who make up a sizeable proportion of the workforce are not necessarily well-placed to make use of them. In part this also reflects the primary concern of many care stakeholders and workers with survival, which in turn squeezes the time and space necessary for innovation; most energy is devoted to day-to-day operational matters concerned with 'keeping their heads above water', rather than long-term strategic thinking. This suggests both that external constraints limit innovation and that a minimal threshold of job quality may be necessary to foster innovation. Hence it follows that poor job quality hinders innovation and stifles better employment outcomes. For the situation to improve a step change in funding availability for the sector would be required.[95] This is a moral as well as an economic consideration.

[95] It is salient to note here that care organisations with relatively more resources (such as HU-CHURCH PROVIDER and UK-FRANCHISE PRIVATE) were better able to implement their own ideas for innovations.

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6 List of Case Study Reports and Industry Profiles

Case studies	
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HU-CHURCH PROVIDER	Patyán L., Makó C., Illéssy M. (2017a). *HU-CHURCH PROVIDER - Innovation in the periphery: The role of supportive management in enriching intrinsic job quality*. Case Study Report for WP6 of the QuInnE project. Unpublished manuscript.
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7 Annex – Summaries of Case Studies

HU-SOCIAL INSTITUTION (Tróbert et al., 2017)

Brief characteristics of the company's structure and business strategy

HU-SOCIAL INSTITUTION operates in a small city with a population of more 30,000 situated not far from Budapest, Hungary. There are more than 5,000 people aged above 65 in the city and around 50 of them use the home care service offered by HU-SOCIAL INSTITUTION. The service is provided by six carers, one of them has a fixed-term employment contract while the others have permanent contracts. Their employment conditions are defined centrally as they are all public service workers. The carers are aged between 40 and 60 years and are all women. They have worked for HU-SOCIAL INSTITUTION for between five and 20 years. The most important challenge for the management at HU-SOCIAL INSTITUTION is constant uncertainty both in terms of financing and professional and administrative regulations. The other major challenge is the need to ensure the labour supply of qualified employees as working conditions are poor, wages are low, there is no opportunity for promotion and HU-SOCIAL INSTITUTION does not have adequate financial resources to promote training of their employees.

Important innovations in recent past

In HU-SOCIAL INSTITUTION, one failed innovation was found. The previous director of HU-SOCIAL INSTITUTION introduced the use of electric bicycles in order to ease the daily transportation of the carers. Financial support from abroad was received to fund this initiative. However, before purchasing the bicycles the director did not listen the opinions of their employees about the innovation and this led to many practical problems. In particular, the bicycle itself is heavy and very difficult to use on uneven surfaces; the maintenance of the bicycles also proved to be a significant problem and the initiative was financially unsustainable. No the innovation activity was evident in HU-SOCIAL INSTITUTION.

Key findings on interrelationships between innovation and job quality, employment and inclusiveness

In the absence of any identifiable innovation activity, the case is an illustrative example of the necessary minimum preconditions of innovation in terms of job quality and the supportive wider institutional arrangements. In particular, frequent changes in the legislation have a substantial impact on the everyday life of institutions such as HU-SOCIAL INSTITUTION, resulting in continuous internal instability. The legal instability concerning eligibility for care, the process of the care work itself coupled with heavy administrative burdens at the employee-level and permanent under-financing at the organisational level. Consequently, the organisation is pushed to its limits in its daily operation. The employees are simultaneously faced with high workloads, low wages, limited career opportunities and a lack of support for further training in the organisation. In addition, care work has a low social status, high psychological strain and high physical demands. It is true that care work does have some positive sides, but overall these jobs are not very attractive. It became obvious at HU-SOCIAL INSTITUTION that the main motive behind why employees decide not to leave their employment was because their job fit well to their individual, specific needs (either they have lower qualification levels or they have a family member who also needs daily care, etc.). The role of these 'stretchy' jobs is to enable extension of the working life, to accommodate disabilities, and to reach a balance work-life balance by offering sustainable employment/social mobility via employee-centred flexibility which is often suitable for older workers and for employees at a transitional stage of their life course. It seems that in a workplace where the management is unable to make mid-term plans and most of the employees are in stretchy jobs, the minimum preconditions are missing for any kind of innovation.

HU-CHURCH PROVIDER (Patyán et al., 2017a)

Brief characteristics of the company's structure and business strategy

HU-CHURCH PROVIDER is operated by a church in a city with a population of over 100,000 situated in the north-eastern region of Hungary. It started home care provision in 2011 with around 80 care receivers, however, the number of the care receivers multiplied by six within a five-year period. In 2016 HU-CHURCH PROVIDER provided home care services for almost 500 clients and it employed more than 50 care givers. The congregation of HU-CHURCH PROVIDER operates three social institutions in the city. These institutions are operated under separate management, but with unified financial and professional coordination. The head of the HU-CHURCH PROVIDER and the financial and professional coordinators play a key role in both the daily operational tasks and in the planning of subsequent activities. The middle management has been minimised in order to reduce costs.

Important innovations in recent past

Although HU-CHURCH PROVIDER is not particularly rich in financial resources, the management actively seeks out areas where an innovation could be implemented. The objective of these attempts is mostly to make the care givers' work easier. The management has been successful in integrating public employees into the organisation providing some of them with the chance for long-term employment (in the other institutions we investigated this was not case). The head of HU-CHURCH PROVIDER also identified that the employees were suffering from burnout syndrome and tried to lighten these burdens both in a short-run by hiring a trainer and in the long-run by introducing an open door policy. New software was developed to make the administrative work of the care givers easier and to support the professional and financial monitoring activity of the management.

Key findings on interrelationships between innovation and job quality, employment and inclusiveness

Domestic care usually offers low quality jobs in an ever increasing service market. Care giving is traditionally a female occupation in Hungary and care giver jobs are typically open to middle-aged people with lower qualifications. The case study showed that an economically depressed area – like the north-eastern part of Hungary – creates a special atmosphere for job seekers: an unemployment rate that is three times higher than the national average and poor quality jobs offered for middle-aged women before they reach the national pension age. These factors have led to a strong engagement from the employees toward both their employer and their job, despite them earning only the legislative national minimum wage. The fast development of the church-oriented services opened up the possibility to hire unemployed people in the form of public employment who can go on to finally become full-time employees. In this way, it is possible for home care services like HU-CHURCH PROVIDER to offer sticky jobs for the new entrant public employees and/or stretchy jobs in the case of those employees who go on to obtain new professional qualifications yet are able to remain employed by the organisation. Two main differences compared to the other two cases in the Hungarian home care sector were apparent. On the one hand, the management at HU-CHURCH PROVIDER seemed to be more active and more innovative. On the other, the church as the owner of the organisation was able to provide some additional financial resources, even though relatively small and definitely not on a regular basis. So, generally speaking, the everyday life of employees in HU-CHURCH PROVIDER does not differ very much from those working in public home care service providers. However, due to the innovative efforts of the management the workers feel valued, which is the basic source of their job satisfaction.

HU-GOVERNMENTAL PROVIDER (Patyán et al., 2017b)

Brief characteristics of the companies' structure and business strategy

HU-GOVERNMENTAL PROVIDER is a government home care service. It is situated in a city with a population of more than 100,000 located in the north-eastern part of the country, which is one of the most disadvantaged regions of Hungary. It supports approximately 2,000 people with more than 200 employees. Its activities include day care centres, meals on wheels and the home care services of the elderly in a municipal associative form. The vast majority (85%) of employees are involved in care for the elderly although it also provides care to people with disabilities and patients with mental health problems. The most important challenge the organisation has faced is the dramatically increasing number of clients, especially in the past 10 years. An important consequence of this sharp rise has been a gradual increase in the burden on care givers. In 1995 one care giver had to provide care for an average of 3.6 clients, but as a result of a continuous rise in demand by 2014 the average number of clients per care giver had risen to 8.9. Despite the constantly growing service need, the organisation is experiencing financial problems due to increased competition coupled with state support schemes that is maintained by the local municipalities that are unfavourable for service providers. Fierce competition has been experienced, especially in recent years, when ecclesiastic and private service providers reached the same service capacity as the municipal institutions. HU-GOVERNMENTAL PROVIDER is facing serious labour shortage problems as other organisations operating in the home care and health care sector are offering higher wages, better working conditions and/or clients with less demanding care needs.

Important innovations in recent past

For the staff working in HU-GOVERNMENTAL PROVIDER the interpretation of the notion of innovation was a serious challenge. The unpredictable changes in the regulatory environment, care protocols and tasks, and in the related funding arrangements create a highly unstable situation. Constant underfinancing has meant the local authority has tried to save money and in an attempt to gain economies of scale, it merged its different service provider institutions: two formerly independent elderly care services, a service for disabled people and a day care centre for mentally ill clients. During the organisational integration, units representing different organisational and management models were united into the organisation. Management developed a unified hierarchical organisational model typical of bureaucratic organisations. The organisation is divided into professional units, where mid-level managerial staff are responsible for carrying out the tasks. The objective was to create a unified organisational identity.

Key findings on interrelationships between innovation and job quality, employment and inclusiveness

The transformation of the organisational structure has not affected the employment level of the organisation. There has been no job loss, neither has there been additional recruitment. The new organisational structure has not increased or reduced the budget, it did not require any investment. As this is a very recent organisational change, it is not yet possible to identify whether there will be any impacts on job quality. Yet the increasing bureaucracy has reduced the autonomy of the employees so they cannot be cooperative partners of the management. The increasing competition changed the profile of the service provision from a quality-based to a quantity-based approach. HU-GOVERNMENTAL PROVIDER has struggled in the increasingly competitive market partly because of the lack of any additional resources and partly because the bureaucratic organisational culture has not enabled the organisation to meet the challenges arising from the fast changing environment.

NL-HOME CARE (Balhuizen and Koene, 2017)

Brief characteristics of the companies' structure and business strategy

NL-HOME CARE is a regional Dutch care organisation that offers welfare, care, living and comfort facilities to more than 20 municipalities in the south-west Netherlands. It is a broad regional organisation that values the local networked nature of care services. It has a divisional structure with, in 2016, care, welfare and comfort divisions. It included both intramural and extramural activities. In 2015 it employed almost 2,000 employees (just over 1,000 full-time equivalent). The Care and Comfort divisions cared for a total of just over 3,000 clients in 2015, of which half were homecare clients. The case study focuses on the care division. In previous years, the organisation had been subject to many health care reforms, putting pressure on income, effectiveness and efficiency. The period until 2016 was characterised by cost-cutting, integration of previously independent organisations into NL-HOME CARE, reorganisation and layoffs. At the same time, NL-HOME CARE had been innovating the coordination of home care in neighbourhoods. Since mid-2016 the organisation has experienced growing demand and increasing pressure on the organisation due to emerging structural labour market shortages of medical personnel.

Important innovations in recent past

The combination of a shifting policy emphasis, changing financing structures, increased cost pressures, the wish to improve the client-focus of homecare, and a call for a re-appreciation of the professional role of home care professionals, has driven initiatives in many homecare organisations to introduce geographically based self-organising teams, embedded in the local community. NL-HOME CARE introduced self-organisation with a central role for the district nurse, who fulfilled a key role in helping clients take a holistic view of their support needs and coordinating and connecting the activities of different actors in the field of welfare, homecare, and other kinds of support that could be required by clients in their neighbourhood environment. Each district nurse also acted as coach and 'captain' of two self-organising home care teams, each embedded in their own neighbourhood. In technological terms an important innovation has been use of video-calling to replace some physical visits to selected clients.

Key findings on interrelationships between innovation and job quality, employment and inclusiveness

An assessment of the case of NL-HOME CARE shows that developments in the home care sector led to top-down management directed efforts at organisational development and change. These were aimed at increasing operational efficiency and dealing with increasing budget cuts and cost pressures, but also at developing a more effective client-focused model of care, with more operational responsibility and discretion for professional nurses and carers. The initiatives were welcomed by the nurses as they reduced bureaucracy, increased professional discretion and replaced bureaucracy with a positive client-orientation. At the same time the cocktail of pressures driving the initiatives created a situation where growing professional discretion and responsibility coupled with cost-reductions and the growing demands on the sector led to increased work pressure and work intensification: developments that challenged job quality. These developments required organisations to shift their focus from downsizing and cost-reduction, which were necessary to cope with the changing societal demands of home care over the past years, towards a focus on recruitment and support of the self-organising home care teams and smart cooperation with other actors in the field. Relatively complex and formalised external financing streams complicated change.

NL-HOME SUPPORT (Oosting and Koene, 2017)

Brief characteristics of the companies' structure and business strategy

The NL-HOME SUPPORT case study documents the developments around the home support unit of a regional Dutch care organisation. The home support unit was part of the Welfare division which included youth support, regional help and support at home. It employed 130 home support workers and provided home support for 900 clients. The home support unit has been subject to several organisational restructurings influencing the jobs and the work environment of the people working within the unit. After the introduction of market forces into the home care sector in 2007, the home support unit was outsourced to a subcontractor. This subcontractor's business was cleaning, with a cleaner's corresponding collective labour agreement for the workers. In 2015, the cleaning company filed for bankruptcy, following budget cuts and a very rate of sick leave (20%). At the request of the municipality NL-HOME SUPPORT took the home support activities back.

Important innovations in recent past

Both parties agreed that changes would be made regarding the role of the home support unit in the care process. The quality of support needed to be improved and innovation through a better inclusion of the home support activities in the care process was agreed by introducing a signalling function into the role of the HS workers. A coordinating nurse was appointed and a training program of four workshops was set up to help the home support workers grow into their new signalling role. At the same time, the responsibilities of the home support workers were redefined from task-based to outcome-based: to ensure 'a clean and liveable home', supporting the client's self-reliance, and providing more person-centred care. Whilst much appreciated by the home support workers, the training programme was put on hold after the first workshop. The coordinating nurse was not only helping the workers with their new signalling role, but also felt the pressure to deal with the signals, which required a lot of informal organisation; much of the work also required coordination between different actors to find efficient and effective solutions.

Key findings on interrelationships between innovation and job quality, employment and inclusiveness

For the home support workers, the relationship with their clients was very important. Helping their client – whom they had been with often for many years, no matter which organisation employed them –gave them a certain dignity and made them very loyal to their clients and the work that needed to be done. The shift towards outcome-based performance, together with the requirement to stimulate self-reliance and involvement of the informal network (neighbours, family) of the client placed the home support worker in a vulnerable position. Finding it difficult to co-opt others and feeling responsible, home support workers often end up doing part of the work in their own time. This came on top of other examples of their already limited ability to influence their working conditions (e.g. finding it difficult to request the right cleaning tools from their clients). Organisational support for these workers, now offered mostly by the coordinating nurse, helped them cope with the increased requirements to set professional boundaries and negotiate with clients and their informal network. Ambitions to extend the role of home support workers, the workshops, and the ability to meet each other were much appreciated by the Home support workers, although it added to their already high workload. The subsequent discontinuation of the workshops, together with the limited resources at the disposal of the coordinating nurse to support the home support workers reflected the remaining ambiguity regarding the position of the home support workers in the care organisation.

UK-FAMILY PUBLIC (Wright and Green, 2017a)

Brief characteristics of the companies' structure and business strategy

UK-FAMILY PUBLIC is a privately-owned family-run care company in eastern England, characterised by a strong ethos to deliver high quality care. Established in 2006, it has seen ongoing growth since start up and ten years later had around 180 employees with recruitment continuing. In the hope of providing a period of guaranteed income stability to invest in provision of quality care the company took a decision to bid for, and won, a 'block' contract (i.e. a sizeable contract guaranteeing provision of care for a set period) from the local commissioning authority to provide publicly-funded home care to vulnerable elderly (and disabled) people in four towns. However, the result of the commissioning process did not work out quite as the commissioning authority or the care company expected: some large care companies exited the market for provision of publicly-funded care while smaller companies remained to compete for smaller 'spot' contracts which proved more financially lucrative than the block contract. The company does not require new staff to have had previous care experience or qualifications; rather they seek to find people with the right values, qualities, attitude and behaviours (i.e. values-based recruitment) and then offer vocational skills training to employees once in post, in line with good practice as set out by the industry workforce development body, Skills for Care. The workforce is overwhelmingly female and White British. Most employees work the equivalent of full-time hours and are engaged on zero hours contracts; take up of guaranteed hours contracts had been low.

Important innovations in recent past

The company is seeking to improve care and intrinsic job quality through the introduction of organisational champions from amongst existing staff members. The impetus behind creating the new roles revolved around improving the quality of care provided to clients, empowering staff and helping them to work better as a team. 'Community champion' and 'dignity champion roles' have been created, with plans for additional champions in the future. Creation of the champion roles links to the company's commitment to providing staff with opportunities to develop their skills and build career pathways. Moreover, the growing size and complexity of the business meant that the owner found that she did not have as much time as she would have liked to directly manage and support her staff. So rather than creating a new layer of management in the organisational structure, the champion roles were a non-hierarchical way of providing additional support to her fast-growing workforce. On the technological front there are plans to move away from paper-based systems for rostering and recording to implement digitalised care plans in order to align with the local commissioning authority's expectations that all contracted care providers have electronic monitoring systems in place, and to provide easier and more timely access to details on the care that has been delivered to all of its clients.

Key findings on interrelationships between innovation and job quality, employment and inclusiveness

Creation of the champion roles may be regarded as an enabling innovation strongly interlinked with job quality. The champions are recruited from amongst existing carers and develop specialist skills in their relevant areas and cascade their knowledge throughout the organisation through provision of peer support to colleagues. It is envisaged that his cascading of knowledge will result in a general upskilling of all employees. The 'champions' innovation also has implications for the way the company interacts with its clients and their families as well as how the company embeds itself in the local community. The innovation is not linked to any change in pay levels or pay principles but rather represents a pragmatic way forward given external financial constraints. Shifting to digitalised care plans is expected to make rostering and monitoring more efficient, but whether this will lead to a change to employment levels or structures is not yet known.

UK-FRANCHISE PRIVATE (Wright and Green, 2017b)

Brief characteristics of the companies' structure and business strategy

UK-FRANCHISE PRIVATE has a franchise structure, with a national office and a number of local franchises across many parts of the UK. Its business model is one of focusing on high quality, privately-funded care. The case study involved interviews at the national office and two local franchises (1 and 2) in the English Midlands. It has decided not to take on large local authority (i.e. publicly-funded) contracts due to the funding constraints associated with them. Rather the business model is one of offering flexible care packages to clients with private funding. Local franchise owners are drawn from backgrounds in senior management across a range of different sectors; generally they have very limited experience (if any) of care before taking on their franchises. The company aspires to be an 'employer of choice' and carers are typically paid slightly above local norms and generally they are engaged on zero hours contracts. The number of workers varies by franchise according to the size of the business; in local franchise 1 there were around 80 workers compared with around 180 in local franchise 2. Women comprise the majority of the workforce. There is a particular emphasis on actively employing older workers. In part this reflects the ethos of the national office team, but it also fits with the company's special emphasis on companionship (i.e. relationship-led care), as well as provision of personal care (as appropriate).

Important innovations in recent past

The franchise model itself may be regarded as innovative, as it allows for local discretion (since each local franchise is independently owned and operated) coupled with national support. At national office level there has been considerable use of geodemographic data in drawing up local franchise territories, while at local level there has been investment in a digital people planning system to enable enhanced scheduling of care visits, with associated improvements in efficiency enabling business growth. In organisational terms considerable attention is paid to matching of carers to clients on the basis of common interests, etc. The company is innovative in terms of the emphasis it places on learning and development to improve the standard of care for clients and to provide enhanced job quality for staff. In local franchise 1 the embedding of a learning culture goes well beyond statutory requirements. There is a particular focus on dementia training but support for education and training extends beyond this. In local franchise 2 a Learning and Development department has been established. The focus here is on improving training in general, developing specific courses for carers and also offering individualised development opportunities for staff members identified as having management potential.

Key findings on interrelationships between innovation and job quality, employment and inclusiveness

Although recruitment criteria were considered slightly more stringent than other care companies given the company's market position at the premium end of the care market, the company is relatively inclusive in that recruitment prioritises finding individuals with a "caring disposition" – rather than formal qualifications. Nevertheless in objective terms many features of extrinsic job quality were similar to, or only marginally better than those in other UK care companies. Given a general ethos that to deliver quality care it is important that workers do not work over long hours the capacity for carers to work very long hours to increase their earnings was curtailed. However, opportunities for learning and development were seen to have a positive impact on job quality in general and also on supporting possibilities for progression. The fact that the franchise operates in the privately funded care market means that financial pressures (although important) are less severe than for companies operating in the publicly-funded care market. The franchise model offers opportunities for learning (between franchises and internationally) regarding job quality and innovation.

UK-METRO PUBLIC (Green and Wright, 2017)

Brief characteristics of the companies' structure and business strategy

UK-METRO PUBLIC is a branch of a private company operating in a large metropolitan area in England, trading under its own name but within a broader group of companies which is one of the largest in the UK providing community-based social care services. The Group was established eight years previously and has grown by acquiring companies of all sizes and by winning new business. The Group is backed by private capital. The branch that is the focus on the case study delivers publicly-funded care under several different contracts in an ethnically and socially diverse metropolitan environment across seven geographically congruent local commissioning areas in a hostile financial environment in which historically cost has been the major factor in commissioning decisions. The precise details of funding available and of procedural and reporting requirements relating to care provision varies across commissioning areas, so creating challenges for the company since it has to deliver care services to nationally prescribed standards of quality within a cost envelope and procedures for dealing with different scenarios set out by different local commissioners. The branch has between 250 and 300 employees (often there are several unskilled vacancies), the vast majority of whom are engaged in carer roles. Over 90 per cent of employees are female and in excess of 80 per cent are from ethnic minority groups (the largest single group being Black-African), encompassing a mix of UK and non-UK citizens.

Important innovations in recent past

A particular focus for innovation in the case of UK-METRO PUBLIC is the contracting arrangements for one of the seven local commissioning areas it has dealings with. In this commissioning area an Ethical Care Charter was introduced by the local council, and the commissioner works closely with contractors to improve care services. The Ethical Care Charter sets certain minimum standards for job quality: it stipulates that care workers will receive a (voluntary) Living Wage (higher than the statutory National Living Wage), will receive recompense for travel time between care visits and will be offered guaranteed hours of work. Another innovation is close collaborative working with the local commissioning authority to raise quality standards for the benefit of clients. Other examples of organisational innovation relate to improvements in dealing with medicine management (prompted by a regulatory need to raise standards) and use of narrative reporting in an attempt to provide enhanced client focused care. Technology has been introduced to facilitate reporting to commissioners and to improve administrative efficiency regarding administrative and workforce planning requirements, while GIS is used to enhance planning of care worker schedules to minimise travelling between calls.

Key findings on interrelationships between innovation and job quality, employment and inclusiveness

Higher pay rates under the Ethical Care Charter raise the floor of extrinsic job quality and are welcomed by care workers. Such rates stimulate different recruitment and retention challenges for the company as more (unsuitable) applicants present themselves for jobs in the sector. The company can be more demanding about its expectations of recruits in local areas where the Ethical Care Charter is implemented than in local areas elsewhere. With regard to guaranteed hours local supply and demand dynamics mean that many care workers choose to retain the flexibility of (objectively worse) zero hours contracts rather than move onto guaranteed hours. The move to increased collaboration with commissioners and other care providers, the introduction of narrative reporting and improvements in medicine management put greater emphasis on literacy skills and operate in the direction of enhanced skill requirements (albeit from a relatively low initial base stipulated for carer recruits). Use of GIS in planning care schedules improves job quality by minimising travel times between calls.