Taking worker productivity to a new level? Electronic Monitoring in homecare – the (re)production of unpaid labour

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This article explores the use of Electronic Monitoring (EM) in homecare and its impact on the ratio of paid and unpaid working time. It argues that whilst Zero Hours Contracts (ZHCs) blur the distinction between paid and unpaid labour, the introduction of EM can formalise and monitor the demarcation between the two. In the context of local authority commissioning and constrained budgets the combination of EM and ZHC's may excise so-called 'unproductive' but available labour from homecare. In particular the minute-by-minute commissioning of care that EM facilitates means the cost of homecare is anchored in the time that worker's spend in client's houses, squeezing out paid travel, time between visits, training and supervision. Paid working time is minimised whilst maximising the use of unpaid time between visits with resulting intensification of care labour.

> *'They said to us, if we went over our time with a service user we wouldn't get paid because that's not the contracted hours. The council won't pay them, so the agency won't pay us. So if we did an extra hour, which happened quite often if somebody had a fall or someone wasn't well and you stay on because it's your duty of care, we wouldn't get paid for that.'* [Care worker, Authority A]

The editors of this journal have outlined the capacity of digital technology to restructure the temporal dimensions of work and called for further focused empirical study (Howcroft and Taylor, 2014). This article explores the impact of the Electronic Monitoring (EM) of homecare work on working time in the context of severe financial pressures on public sector provision of social care in the UK. Homecare workers are overwhelmingly women and provide personal care to older and disabled people in their own homes (referred to as 'service-users' or 'clients'). The vast majority are employed by private sector organisations delivering care that has been commissioned on a cost competitive basis by local authorities (Bessa, 2013; Rubery et al., 2015). It is proposed that EM in combination with Zero Hours Contracts (ZHCs) contribute to the reconfiguration of paid and unpaid working time because they enable the removal of what might be deemed 'unproductive' working time through 'client contact only payments' (where providers are paid only for the time that care workers are in the service-user's home).

The article focusses upon the narrative underpinning the development of EM and local authority commissioners' requirements for EM in the commissioning and performance of local authority contracts. The discourse is one of improved compliance, efficiency and quality assurance. It had been argued that increased productivity in care work was problematic (Himmelweit, 2005). However, the introduction of EM offers a new level of managerial control in an occupation where it had not been possible because of the location of work in service-user's homes. The requirement for homecare providers to use EM systems means that care visits can be measured and costed in quantitative terms. Time sheets are replaced by integrated computer-telephone technology to log, analyse, report on and invoice service user visits. In the case studies discussed below EM involved workers logging in and out through service-user's telephones, but they may also do so by swiping tags on service-users files with smart phones or may be tracked through smart phones via GPS technology.

Whilst EM is used to monitor the real-time location of workers the case studies show that it is also being used to delineate paid working time. For Marx, an increase in the rate of surplus value may be achieved through the extensification of labour time (absolute surplus-value) or increases in productivity, technical improvements and/or work intensification involving change in the utilisation of work (relative

surplus-value) (1976). Work intensification may entail the reduction of paid labour time and an increase in the ratio of unpaid to paid working time (Mavroudeas and Ioannides, 2011). The majority of homecare workers are employed on Zero Hours Contracts (ZHCs) (Skills for Care, 2016) where there is no legal obligation between employers and workers to provide or perform work (Adams and Deakin, 2014), reflecting employer preferences for work-on-demand scheduling (Jacobs and Padavic, 2015). ZHCs facilitate episodic or intermittent paid working time (unpaid waiting time between visits) alongside the non-payment of travel time between home visits, with implications for the application of statutory hourly minima (Bessa et al., 2011).

If ZHCs shift the ratio of paid to unpaid labour through contractual means, this research shows how EM provides the technological capacity to differentiate paid and unpaid labour. In order to avoid the 'evangelical' approach to 'IT-enabled change' (Bergvall-Kareborn and Howcroft, 2014: 213) and 'familiar flaw of technological determinism' (Howcroft and Taylor, 2014:1) this article will place emphasis upon the wider political economy of public service provision and the marketization of care in the context of the retrenchment of the welfare state (Dominelli and Hoogvelt, 1996). In addition, the importance of political agency will be highlighted. In a small number of local authorities the adoption of the UK public sector union, UNISON's, Ethical Care Charter[1] mediates the use of ZHCs and EM by commissioning on the basis of higher charge rates for homecare and thus a Living Wage and paid travel time for homecare workers. The research problematizes the contingency of EM's relationship with the contractual status of homecare workers, exploring the inter-relationship of the two under different commissioning regimes. As is evident below, the minute by minute commissioning of care introduced by one local authority represents a qualitative and quantitative step-change.

The article begins by conceptualising reorganised working time in homecare. The research is located in the context of the political economy of care - the swingeing cuts to adult social care and downward pressure on local authority commissioning. The prevalence of ZHCs in homecare is highlighted as providing the contractual underpinning for EM in the context of attempts by local authorities to reduce the costs of care. The methodological basis of the research, two case studies of local authority commissioning in the south west of England (with wider reference to nine case studies where UNISON's Ethical Care Charter has been adopted) is then presented. The findings draw upon textual evidence in the form of commissioning and supplier documentation, as well as interviews with representatives of local authorities, suppliers and providers, to explore how a narrative legitimatising the introduction of EM has been produced. The argument is that the introduction of EM may go beyond concerns for compliance, adult safeguarding and care quality and be driven by cost savings realised through the excision of what is considered to be 'unproductive' paid working time whilst workers remain available to the employer. The implications of EM for the labour process, managerial control, contestation of the boundary between paid and unpaid labour and workers' capacity for discretionary care are then examined.

The Political Economy of Homecare

Almost all (97 per cent) homecare workers in England are employed outside the public sector; either working for independent sector contractors or directly employed via direct payments (Skills for Care, 2013). Despite increasing demand there have been significant cuts in adult social care budgets and intense pressure on labour costs (ADASS, 2016). A 2015 study by Employers' Federation, the UK Homecare Association (UKHCA), found that almost 90 per cent of local authorities across the UK were paying an hourly contractual (charge) rate less than £15.74; the minimum price at which it calculated employers can fully comply with minimum labour standards, including care workers' travel time as paid time for the purposes of what was then the National Minimum Wage[2] (NMW)).

The ability of providers to deliver contracts based upon local authority set charge-rates depends upon ZHCs. They have become standard across the homecare sector with 58 per cent of homecare workers calculated to be on ZHCs in 2016 (Skills for Care, 2016). By creating periods of unpaid labour within working time homecare workers pay may breach statutory requirements once hourly rates are averaged out over the time they are effectively available to the employer. This may include periods of 'waiting time' or 'down time' between visits, training, supervision or travel time. The UKHCA has estimated that travel time comprises an average of 19 per cent of available hours and is generally unpaid (2012)[3]. The UKHCA's 2015 survey (2015) suggested that no London borough was paying an hourly rate sufficient to support the London Living Wage[4] (advocated in the Ethical Care Charter):

> Where councils pay an unrealistic price while expecting a Living Wage they run the risk that their providers cease to be economically viable, or that areas such as training and care coordination are sacrificed to increase wages to the required rate. In reality the aspirations of such councils are little more than empty promises to local workers.

Unpaid working time has become embedded in the organisation of homecare. ZHCs facilitate the elimination of 'unproductive' time, with the boundaries between paid and unpaid working time blurred since care workers are required to be available to their employers without guarantees of paid work. However, the increased requirement by local authorities for EM can locate the worker within the service users' home as the basis of paid work introducing a clear demarcation between paid and unpaid labour.

Theorising Electronic Monitoring and the temporal dimensions of work

Whilst an increased heterogeneity, fragmentation and intermittency of working time has been associated with a departure from a Taylorist model (Supiot, 2001), there is evidence that 'the legacy of Taylorism has endured' (Ellis and Taylor, 2006: 110). Dominelli and Hoogvelt (1996) identified how re-organisation of local authority functions and duties insisted on a purchaser-provider split and 'contract government' that required 'inputs and outputs be operationalized, measured, costed and evaluated' (1996: 52). They concluded that the fragmentation of the care labour process mimicked Taylorism. Work intensification in homecare is enshrined in the 'care package', a term that suggests a commodity rather than a relationship, and homecare is increasingly a task-based service governed by the clock.

Marxist theory of Relative Surplus Value (1976) is useful in explaining the intensification of working time and conceptualising the shifting relationship between paid and unpaid labour which both ZHCs and EM deliver. It describes how increased productivity may be achieved through technology and/or the condensation of labour through 'a closer filling up of the pores of the working day' (Marx, 1976: 534); in Green's words 'those gaps between tasks during which the body or mind rests' (2001, 56) and which for homecare workers over the past decades have been paid. Parallels can be drawn with a study of mobile hairdressers who also undertake *mobility for work* and where time between visits has been characterised as 'dead' or 'baggy' time or 'unproductive spatio-temporal in-betweens' (Cohen 2010). The extent of time-space dependence and employment status are key mediating factors in worker autonomy and control (Cohen: 2010:75-76). In the UK state provision of homecare evolved from a 'home helps' service established during the Second World War and provided by women on an informal and partly-paid basis (Dexter and Harbert, 1983). From the 1970s onwards homecare work was gradually established as formal employment with regular fixed hours, written contracts, employment security, access to an occupational pension and latterly, to equal pay. Since the demand for homecare peaks at certain times in the day (mornings, lunchtimes, evenings and bed-times) Herbert and Dexter (1983) observed that having to recognise homecare workers' time in full, and having to acknowledge fixed and regular hours of work ran a risk of 'the home help being paid for doing nothing' introducing costs for homecare services. The transfer of homecare workers from direct employment by the local authority to the private sector involved the introduction of ZHCs and eradication of so-called paid 'down-

time' between homecare visits. The gendered history of homecare provides the context for the restoration of unpaid work.

What has been described as 'the homogenisation of working time', extends the real subsumption of labour and capital's permeation into free time, with labour increasingly available to capital (Bell and Tuckman 2002). There is a blurring of the line between time expended in 'labour' (where labour is sold as a commodity), and 'free time' outside of that contract and the encroachment of commodified time into free time (referred to as 'partial commodification') (Tuckman 2005). Tuckman identifies increased decommodification (distinct from Esping-Anderson's conceptualisation of the role of the welfare state in valorising labour (1999)) of 'labour necessary for the immediate preparation for productive activity' and the disruption of continuous commodified time. This conceptualisation of decommodification has been previously applied in research on changes in the labour process in US healthcare: in the context of cost cutting, paid female waged work was replaced or reshaped by female unpaid domestic labour (Glazer, 1998). Tuckman's position recalls Supiot's (2001) argument that there is a dialectical relationship between paid and unpaid labour in which boundaries between free and working time are regarded as permeable. This leads to uncertainty over the time that employees are 'available' to the employer and, according to Supiot (2001), this is time that is neither clearly working time nor clearly free time. In homecare, ZHCs mean there is lack of clarity as to which parts of the day are paid, despite continuous availability to the employer. As Glazer demonstrated, when set in the specific context of marketised homecare the shifting boundaries between commodified and de-commodified time take on a particular gendered character.

A three year study of the recruitment and retention of the wider social care workforce in public and private sectors confirms the potential for EM in homecare to reduce pay by 'restricting paid work time, to time actually spent in people's houses' (Rubery et al. 2011:345). Whilst ZHCs may blur the relationship between paid and unpaid labour time, the introduction ofEM clearly delineates the time spent by care workers in the service user's home. EM may be a monitoring tool to locate workers in the interests of service-users, yet where pay is restricted to contact time only it becomes a mechanism to demarcate paid and unpaid working time and normalises unpaid working time. In legal terms it has been argued that the bifurcation of working time into periods characterised as 'active' and 'inactive', hinging upon availability to the employer, allows 'the carving out of "inactive" periods from the parameters of regulated work across labour markets as a whole' (McCann and Murray 2014:342). Whilst ZHCs and EM can operate in a mutually exclusive manner, in the context of budget cuts they can become interdependent.

The legacy of gendered domestic labour has underpinned the notion of discretionary ('extra' care given outside paid working hours at the discretion of workers) labour in care work and the blurring of the boundaries between informal and formal work (Aronson and Neysmith, 1996). It has been suggested that a gendered and ethically driven propensity to care may inhibit the articulation of interest as workers (Folbre, 2001) with care workers individually compensating for cuts to services or the increasing depersonalisation of care (Aronson and Neysmith, 1996) through discretionary effort or unpaid labour time.

A workplace survey suggested that EM led to the intensification of homecare workers' labour, but that discretionary effort was not reduced (Brown and Korzcynski 2010). However, the research cohort concerned homecare workers directly employed by the local authority the survey did not examine EM in the context of marketised cost competition and private provision. Technology shapes the labour process, including social relationships (Prichard et al, 2014; Ball, 2010) and as the case studies below show, the excision of 'unproductive' labour facilitated by EM squeezes the relational aspects of care that are embedded within commodified relationships (Ungerson, 1999). Where EM makes it absolutely

clear that their time is unpaid, as Folbre warns, over time the 'exploitation of worker empathy may undermine' the discretionary effort upon which homecare has been dependent (2012:612).

Methods

As the introductory quote indicates, while workers' subjective experience of technology is crucial (Hayes and Moore, 2016), the focus of this article is on the rationale for EM from the perspective of the technology supplier and technology design (Collin-Jacques and Smith, 2005); and its legitimation by local authority commissioners, managers and their homecare providers. It highlights the temporal commissioning of care that EM facilitates in one of the case study authorities.

The study, funded through a British Academy/Leverhulme grant, is based upon case studies of homecare commissioning in two neighbouring local authorities (Authority A and Authority B) in the South West of England and took place between 2014 and 2015. The case study method facilitated a combination of data collection methods from a variety of sources (Dooley, 2002). The wider context for the case studies - the rationale for the implementation of EM systems - was provided by interviews with representatives of the technology supplier and textual analysis of their sales and publicity material, including published case studies of implementation.

The selection of case studies was largely pragmatic and driven by local accessibility. While the South West case studies cannot claim to be representative of all local authority commissioning of care, the comparison of two local authorities within a similar labour market (dealing with the same national budgetary pressures) is instructive in capturing the scope for variation in the adoption and application of tendering requirements including EM. Triangulation was achieved through analysis of EM in the homecare strategies of nine organisations that had adopted UNISON's ECC, including seven local authorities (based upon interviews with 18 local authority commissioning or service managers, 9 providers, 11 care workers and 13 UNISON representatives). Their adoption of the ECC suggests the capacity for political agency in a constrained economic context. The ECC research also reveals that the maximum rates providers could charge for care in the two case study authorities detailed below were towards the lower end of the spectrum. In addition the role of EM in various local authorities was captured through public documentation of the commissioning process available on their websites. This was supplemented by previous work carried out by both researchers, which included participation in five case studies of homecare for the Low Pay Commission in the period prior to this research (Bessa et al., 2013) and a three year research fellowship focused on developing a socio-legal ethnographic account of working in homecare explored through the lens of labour law (Hayes, 2017).

Data on commissioning in the two South West authorities was drawn from supporting documentation including commissioning strategies, consultations and tender documents. This was complemented by interviews with two representatives of the supplier of electronic monitoring software/systems; seven in-depth interviews with six local authority officers involved in the commissioning of homecare services and service management; and five interviews with senior managers or owners of three homecare providers. Interviews focussed on the commissioning process and the use and implementation of EM. Local authority officers provided contacts with homecare providers in the two authorities. Senior managers or owners of three homecare providers were interviewed, one from a large national company in Authority B and two from smaller local companies, one in Authority A and one that delivered across both authorities. While only three interviews took place with providers, these participants were solely responsible for tendering at the local level and had intimate knowledge of the process. Since re-commissioning in one authority was prolonged, the research took on a longitudinal perspective with re-interviews with commissioners and providers to capture the tendering process and its outcomes. All interviews were face-to-face, based upon informed consent and recorded and transcribed: they lasted approximately 90 minutes.

Written and spoken texts were subjected to critical discourse analysis (Roper et al. 2010), starting with micro-level textual analysis to identify the stated rationales behind the development, introduction, implementation and marketing of EM. This captured dissonance between theory and practice, particularly where financial savings was introduced in both supplier publicity material and local authority officer interviews. Macro-analysis illuminated the way the political economy of care drove wider social-political practices that shaped the texts, but were also influenced by them, thereby providing organisational, social and political contextualisation (Roper et al. 2010).

Homecare commissioning and Zero Hours Contracts – the contractual basis for EM?

ZHCs were embedded in homecare in both authorities and this was financially driven with the allocation of care packages largely on the basis of cost. In Authority B the re-commissioning process had promoted an hourly Living Wage and the option of fixed hour contracts to move away from ZHCs; however the maximum charge rate had been set at a rate which could apparently accommodate neither, as the local manager for one national provider commented:

> The most frightening thing about the whole process is the charge rate and the maximum they've set it at is £14.20, which is a cut for us. We're trying to pay our homecare workers a living wage, we're trying to pay appropriate mileage, travel time and on the margins that you've got on the charge rate that the local authority are setting you can't do all of that - it is impossible.'

In fact, this provider lost out in the recommissioning process, reporting that one of the four successful providers had tendered at £12.20 an hour – a rate which the Director of the company stated was 'unviable'. In general, commissioning procedures set maximum charges for homecare with a single rate for all categories of care and service-user groups on a 24 hour, seven days per week basis. There is a disincentive for the provider to pay any enhancements for weekend and evening rates as well as payment of travel time. One provider who contracted with both authorities pointed to the contracting-out of local authority jobs as key to eliminating so-called 'down time' from labour costs since privatisation signalled the end of the secure employment previously available to local authority homecare workers:

> If we employed care staff on a permanent contract, the rates would be higher because it will push up the costs. We pay statutory sick pay, they get holiday pay now, but there's going to be down time - that was the biggest problem that the local authorities had when they provided in-house care. Well the local authorities employed homecare assistants on fixed contracts, fixed hours, so they would work from 8am till 4pm. They would be busy from 8am till 12pm or 2pm and then the rest of the day there was nothing else to do, but they were being paid for that time. The majority of our people are on Zero Hours Contracts – obviously there's no down time'.

ZHCs, in the context of local authority commissioning, have marked a move away from fixed hours contracts based upon consolidated paid working time, where all aspects of the working day and night (travel and time between visits, supervision, staff meetings, unsocial hours, management and the general sharing of practice) were recognised and rewarded. ZHCs facilitate the removal of what was hitherto paid working time during periods of 'low demand' from homecare workers' schedules and this is the context for the introduction of EM.

Electronic Monitoring – rationale and reality

Tender documents increasingly stipulate that providers use specified EM systems. Authority A had required Framework providers to adopt EM since 2009, but in 2014 were required to use the Council's centralised system with the local authority contributing to the costs of implementation. Authority B had

previously only expected larger providers to use EM, but it was now a requirement to use the same Council system as Authority A under the re-commissioning process, with the introduction of Key Performance Indicators (KPIs) based, for example, on the proportion of late visits measured through EM. Care work is thus 'reconstituted in the abstract' through performance metrics (Zureik, 2003:39). When a care worker arrives at a service users' home they dial their unique number to the EM supplier's call processing centre. The system matches the service user's telephone number to the database of service users, logging the time the call was made and matching this to the roster/schedule of care – the care worker repeats the procedure when leaving to log the length of the visit. Where the local authority specifies its supplier it owns the Intellectual Property Rights (IPR) to information on the EM system; the Council's system shows instantly if a visit has been missed or if the homecare worker is late or leaves early and system alerts allow council officers to deal with these immediately. Observation of the system in council offices testifies to the irony that whilst local authorities no longer directly employ care workers, a computer screen shows in real time whether a named worker employed by a provider has entered, is inside or has left a service users' home and in an adjacent column simultaneously calculates the cost of the visit to the Council.

While 'the rhetoric of safety' may support the use of surveillance technologies, it is not their only objective and there is a tension in the employment relationship between workplace surveillance as coercive and protective/performance-enhancing (Rosenblat et al. 2014). The case studies show that three narratives legitimised the use of EM: worker and provider compliance; safeguarding for service users and care workers; and financial savings. Commissioning documentation and interviews with local authority officers generally embraced all three narratives and moved between them. The leading supplier of EM claimed in its publicity materials that systems were designed to improve efficiency and quality assurance in homecare safeguarding both service users and staff. Authority A stated that it had introduced EM for various reasons including to promote safety for lone workers and service users, to improve the quality and visibility of the service, to reduce the pressure on the service user to sign timesheets evidencing care received and to ensure invoices from providers were linked to actual hours of care commissioned and delivered. Analysis of other local authority web-sites revealed that explanations for the use of EM included recognition of 'national imperatives to rationalize the way domiciliary care is commissioned' (Bolton Council, 2009:2); improved safety for care workers and service users (Wrexham Council, 2010-15); ability to 'make efficient and accurate payments to care providers' (Leicester Equality Impact Assessment, Domiciliary Care Contracts 2011-2015:8) and the reduction in service-user complaints about poor time-keeping (London Borough of Bromley, 2010).

Crucially supplier marketing material promises savings because local authorities pay only for the costs of the *actual* care delivered. For local authorities the system offers a three-way analysis of *commissioned (purchased)* time versus *planned (scheduled)* time versus *actual (delivered)* time. This was explained as follows by a Marketing Manager for the system:

> 'What's commissioned compared with what's planned, compared with what's actually delivered, is totally different. So quite often the planned care package, once it goes out to an external provider, will be somewhere between 10 and 20 per cent different from what was commissioned largely based on the ability of the care provider to actually deliver for that service user. And that's understood within the market to be a key dynamic. For many councils, it was about making sure that they were only paying for the care that was delivered once they'd outsourced the bulk of their homecare'.

In a context where demand for care fluctuates significantly on a weekly basis, providers are paid for time spent in 'actual care delivered' and are penalised if visits exceed planned or commissioned time (unless they can demonstrate exceptional circumstances). The supplier had worked with 65 local

authorities and reported significant financial benefits. One county council claimed savings of £1 million in the first year following adoption of EM.

In Authority A, EM allowed the Council to reduce administration with the automation of timesheets and to save time on producing invoices, which are generated directly from the EM system and 'linked efficiently to actual hours of care commissioned' (case study published by supplier, 2009). It was reported that since the authority had begun paying for only the care delivered it had made ten per cent savings in its Adult Social Care purchasing budget. Invoices are paid only if they are submitted via the system (in exceptions the provider is charged by the Council for processing invoices) and where the total visit time is within the parameters defined by the Council. Where visits are in excess of a ten per cent tolerance period, there is an investigation and payment will not be authorised if it is considered that variation is not justified. Payments are not made when visits have been logged incorrectly.

A commissioning officer with responsibility for quality from Authority B legitimated EM in terms of compliance and safeguarding staff rather than cost, although she was more sceptical about protecting the quality of care:

> I think at the beginning, some of the care workers found it a bit of a faff, felt it was a bit big brother-ish, which you can understand, also you can understand some of them might have felt that it was there because of a lack of trust. It's better for the staff because of the fact that they can prove they've been there. They can prove they arrived, and when they left. They can't prove what they did in between, but at least they can prove something. I don't think it's a way of saving money, that's my feeling, but I work on the quality assurance side. The primary function is to make sure that people are turning up and reassurance that people are going to turn up on time and that something happens if they don't.

However, in common with Local Authority A, the Commissioning Manager also reported financial savings, including in circumstances where a service user decided they did not want a scheduled visit at the point when the care worker turned up:

> We've had a cost saving since we've introduced [EM]. What we were doing was we were paying providers on what we commissioned, so if we commissioned 'x' number of hours, they would then be paid for 'x' number of hours, what we now do is we pay providers on what we call actuals, so the actual time they've spent with the service user, because we were paying too much, because often what was provided wasn't what was commissioned - perhaps the service user's needs changed or often it can be the case that they would say to the provider 'I don't want you today because my daughter's here or whatever' - there's a legitimate reason for turning the provider away.

In such circumstances the authority would not pay the provider and it is likely that the homecare worker would not be paid. The requirement for providers to use EM prevents them from overriding the system by manually entering data from their offices. This was tolerated under the previous voluntary system on the basis that care workers might forget to log-in or log-out or service users would not allow them to use their phones or service user's phones may be busy. In Local Authority B EM was anticipated to reduce 'illegitimate' manual entries since the Council could monitor centrally on a real-time basis. While there was still some tolerance of the failure to log in and out the dominant perception of council managers was that both providers and care workers had been able to manipulate the system to cover up for missed or shortened visits. One provider working across both authorities commented

> I think people forget to do it, and in some cases genuinely. I think other cases they're trying to work the system. If you don't log out and you go on to your next call you can log in somewhere else [although] you can't possibly be in the same place at the same time. So you've got a 30

minute call, you might have only stayed 20 minutes but you haven't logged out so you're at the next clients. Whereas if they'd have stayed their full 30 minutes, - you can't be at Gladys's at twenty past seven when you only got to Bert's at 7, and it's a 30 minute call. So they're shortcutting the calls or – so it can be worked. It can be abused shall we say, not worked, and obviously we have to as providers clamp down on that and try and address those things.

Interviews with homecare workers suggested that genuinely forgetting to log-in or out was a common occurrence and under EM could result in neither the worker nor the homecare provider being paid for the visit. Time and tracking technologies can be used to constrain employee attempts to 'steal' time from employers (Ehrenreich, 2001) and in the case of homecare commissioning this extends to providers. EM can ensure that visits are not cut short ('clipping') because of the pressures of 'call cramming' (back-to-back visits with insufficient time between them for the care worker to reach her next visit on time), where care workers may be trying to catch up on visits. Call Cramming provides an incentive for workers to cut calls short in order to minimise unpaid time between visits and this is further encouraged where travel time is insufficient or not paid; 'clipping' may allow care workers to claw back some paid working time. EM prevents this since it delineates and polices paid and unpaid time. For homecare workers, real-time surveillance means any space for the contestation of the boundary between paid and unpaid labour is reduced.

Minute by Minute commissioning

Local Authority A commissioned on contact time, but careworkers were paid in 'bands', so initially for a minimum of 30 minutes and then to the nearest 15 minutes thereafter, providing some flexibility. However, in Authority B re-commissioning meant providers would only be able to charge for contact time on a minute by minute basis. The requirement to adopt EM involved a move from a banding system, where workers would be paid to the nearest 15 minutes, to being paid by the minute, as a provider anticipated:

> If they do minute by minute billing, and that person leaves early, they will only get paid their 20minutes, whereas at the moment, if the girls stay over 23 minutes they get paid for a 30 minute call.

Here all directly 'unproductive' time is squeezed out of the system. For commissioners this means care workers do not 'hang around' (apparently unproductive) to the cut-off point of a visit as they may do under the banding system – minute-by-minute commissioning removes the incentive to work to the cut-off point since workers know they are not paid to 'hang around'. It potentially means that more calls can be scheduled, so pressure to move on to the next service-user is maintained, but paid working time is minimised whilst maximising the use of unpaid time between visits. This is the intensification of care labour.

Provider overheads and any profit margins have to be recouped from the difference between the hourly charge rate *as delivered* and the hourly wage. Any costs associated with time for training, management, supervision or travel have to be paid by providers out of actual contact time. One provider working across both authorities reported that the organisation could not pay staff for training, although it paid for their travel to training events and provided lunch as compensation. A Commissioning Officer in Authority B recognised that care workers were trained on their days off and this was unpaid. For a national provider EM in the context of the Council's maximum charge rates squeezed overheads and potential profit:

> Well they're saving, if the carers are going in and it's a 30 minute call and they go in for 20 minutes, they only get paid for the 20 minutes. So in a week if that happened, it all adds up doesn't it and if you're doing a lot of calls it's going to add up somewhere along the line isn't

it? When you think what has got to come out of that hourly charge rate it's frightening – we put in the cost of the manager, the cost of the coordinator or two coordinators, the cost of senior carers, the cost of an office, the cost of the organisation's umbrella - HR all of that – then there's the IT, the EM system, the expenditure on that – that's all got to come out of the £14.20. [The] hourly pay rate – the lowest rate is £7.45, national insurance, pensions –you try and work out the maths because I can't! The person from the bid team [in the organisation] that was doing it came back to me and said 'are you having a laugh?' and I said 'no I'm not that is the highest we can bid at', she said 'you just can't do it'.

This observation attests to the closing of the porosity of the working day, which had hitherto been used to compensate for unpaid elements. Homecare workers interviewed regarded their 'working time' as the length of time for which they wore their uniform. Applying this measure, only about half of their working time would qualify for pay under EM on a typical day with workers penalised for running late, whether through call cramming, the unexpected demands of service users or travel difficulties. Even a well-organised work schedule could involve an hour and a half of unpaid 'hold ups' each day and one worker appreciated that, 'over a week, that's nearly a whole day's pay that you are working for nothing'. Another reported committing herself to working a 15 hour day and receiving between 5-8 hours pay. Perversely, a greater intensity of work could result in less pay where rotas were crammed with more calls than could be properly serviced since each separate visit introduced new sources of potential unpaid time. The colleague of one care worker interviewed had calculated that the introduction of EM had resulted in a wage drop of £50 a week.

In the case studies of authorities that had adopted UNISON's ECC only one of the seven authorities paid providers on contact time to the minute. Significantly, one of this authority's providers reported that it absorbed the difference between contact and scheduled time in order to protect care worker's pay and avoid staff turnover; she suggested that providers often accommodate such costs. The other authorities rejected minute by minute commissioning as incompatible with ethical care. Minute by minute commissioning represents a further step change in homecare since it goes beyond pay based upon time bands, in closing *any* temporal gaps in which homecare workers can claw back unpaid working time and excising *all* apparently 'unproductive' labour time for the purposes of pay.

The quality of work and discretionary labour

Homecare workers clearly understood EM as a system which set limitations on their pay, anchoring paid time within service users' homes. It was also perceived as a disembodied power that undermined their discretion and capacity to reconstruct their working time, possibly to demonstrate or manufacture compliance (Levy, 2015). EM is used to ensure that the worker has to stay until the end of the service-users' allotted time in order to be paid even if when judged that she is not required. By the same token, the availability of paid working time might not correspond with the time needed to fulfil tasks specified in the care plan. In the context of the unpredictable nature of homecare work where service-users are vulnerable, homecare workers may choose to stay beyond scheduled time, particularly in an emergency.   As one explained, 'you can't just walk out of the door and leave and say 'well, my time is up now, I've got to go!', but staying longer than scheduled meant spending time without pay. Homecare workers experience a dissonance between their desire to provide holistic care and their need to work on the basis of task-orientated time rationing (Ungerson 1993: 201). Many homecare workers concluded that EM affected the quality of care they were able to provide. A Service Manager in Local Authority A conceded that it does not necessarily provide quality assurance:

I think it was introduced supposedly for quality purposes, although my personal opinion is that it doesn't monitor quality, it's finance driven actually. Before we would pay for what we'd commissioned, so now we pay for the actual; so if they were there for 29 minutes we pay for 29 minutes. All it does is tells you that somebody turned up, it doesn't tell you what they did. It

doesn't talk about the attitude to the way that they provided care, it just tells you that they were in the house for half an hour; they could have been sat there.

The qualified confidence which local authority officers and providers had in EM does not suggest the levels of trust and discretion that Prichard, et al. (2014) identified as key to mediating the introduction of technological systems that imply high levels of managerial control. In homecare the direct relationship between service delivery, contractors' invoices and workers' pay, places extreme pressure on discretionary labour, something the care system has historically depended upon. Recognition that relational aspects of care are increasingly unpaid is captured in a provider's comment:

> We have had cases where someone has stayed to have a chat with a service-user – well Local Authority B aren't going to pay us for the homecare worker to stay and have a chat with them. We tell the worker 'that's your time. Log out of your time and then stay and have a chat if you like but you need to go on to your other clients'.

In a slightly contradictory remark demonstrating the tension between service quality and cost, this provider mentioned that EM had been abandoned at a neighbouring Council, where she had previously delivered services:

> The carers don't like EM and we had a huge resistance when it was first introduced. And in fact they introduced the electronic monitoring and what happened was it affected the quality, the relationship between the carer and the client. It was clock watching – and you hear the 'we need to come on, get a move on' sort of thing and 'I've got to get to the next person'. Well we don't have a choice in it, we won't have any work if we don't comply - [Local Authority B] felt that they were paying more, they could pay less. It was financial.

EM was seen to further reduce paid care-giving to an attempt to fulfil of a series of tasks within a pre-determined time period, increasingly focussed upon operation of the telephone system.

As Glucksman (1995; 2005) explains, care work sits on a conceptual fault-line dividing social understanding of the world of paid work, from that of 'economic inactivity' associated with the private, domestic realm of home and family. Previous studies have identified the difficulties of separating formal and informal labour in care work (Bolton and Wibberley, 2014) and of thus distinguishing between paid and unpaid work. Where cost-cutting drives the depersonalisation of the labour process and the formal description of care work does not correspond to the worker's reality (Aronson and Neysmith, 1996) discretionary or unpaid care work has been seen as resistance (Glazer, 1993; Baines, 2004; Hochschild, 2009). One homecare worker recounted that she would return to her service users later in the day to finish duties in her own time which she had been unable to complete within the confines of electronically monitored time. However, the voluntary nature of discretionary labour has been questioned (Aronson and Neysmith, 1996) and other interviewees were either unwilling or unable to engage in such unpaid activity. In Bolton and Wibberley's (2014) terms, while ZHCs might blur formal and informal labour, EM explicitly demarcates it echoing the introduction of dichotomies between productive and unproductive and consequently paid and unpaid time. EM would appear to constrain the capacity for discretionary labour from care work. Rather than recognising and paying for the relational aspects of care often delivered through the discretionary labour of women, these elements of thelabour process have become totally devalued alongside women's pay.

Conclusions

According to the EM supplier and the local authorities that have adopted it the introduction of EM in homecare delivery is motivated by a desire to safeguard service users, to ensure the physical safety of care workers and, by policing compliance, to improve the quality of care. The research presented here

suggests that EM goes beyond the recording of working time (Cockburn and Ormerod, 1993). In the context of austerity and cuts in local authority budgets the key drivers are financial, supporting Zureik's conclusion that the surveillance of work cannot be severed from the surrounding political and economic environment (2003). In homecare, labour intensification is delivered through the commissioning process, which facilitates episodic working time based on contact time and underpinned by ZHCs. Here boundaries between paid and unpaid work are blurred because it is unclear whether travel time and the 'down' time between visits represent working time for the purposes of pay. While hourly rates for homecare workers may be formally at or above the level of what was then the National Minimum Wage (and in some cases the Living Wage) an increasing proportion of working time is unpaid. This is not just a problem in homecare. A *Guardian* investigation into Sports Direct, where 80 per cent of warehouse workers were on ZHCs, found that effectively they were paid below the NMW because of the non-payment of time for on-site security searches[5]. Using Marx's metaphor of actors on stage waiting in the wings, Tuckman's (2005) analysis points to the increased availability of labour to capital that ZHCs entail.

It is possible for local authorities to use EM to simply ensure that homecare workers are in service users' homes as commissioned; to protect them from allegations of missed and late visits; and to automate and simplify invoicing. Yet there is little evidence that EM has the potential to empower workers (Zureik, 2003). Rather in some authorities EM, in contrast to ZHCs, enforces a spatial and temporal delineation which is then used to formalise and demarcate paid and unpaid work, while simultaneously demanding unbounded availability from the worker. Where EM is applied in this way ZHCs provide the necessary contractual basis. In one configuration EM may prevent homecare workers from leaving before the end of commissioned time so that they cannot claw back unpaid travel time. In another, minute-by-minute commissioning squeezes out 'unproductive' labour ('hanging around') and by costing care on the basis of time in the service-users' home places huge pressures on payment for travel time as well as paid training and supervision. It further shifts the ratio between paid and unpaid working time. This situation is driven by local authority charge rates and minute-by-minute commissioning would appear to be incompatible with adoption of UNISON's Ethical Care Charter, which demands a charge rate nearer to the full costs of labour as well as an end to ZHCs.

In combination, ZHC and EM strip so-called 'unproductive' labour from care work. Confounding Himmelweit (2005), this assessment suggests the market has found a way to increase productivity in care. Nevertheless, this involves an attack on both the relational aspects and quality of care,reducing it to a series of tasks in the Taylorist fashion. Paradoxically, the introduction of EM removes the discretionary labour that gendered care has historically relied upon, yet does so in a manner that degrades, rather than valorises, care work.

As Glazer (1998) argued, the decommodification of women's care work is in the interests of capital. The removal of state support for welfare and social care in the context of neoliberal capitalism has profound effects upon women's paid care labour and the value of care. In this context, the excision of paid labour from care work is highly gendered. The process may serve, from the perspective of the state and its withdrawal from social provision, to legitimate the partial restoration of unpaid work in homecare; a regressive step away from the recognition of care as paid work with collective employment rights. The reliance of care for the elderly upon the unpaid labour of largely women workers is part of the lurch towards, what Fraser (2011) has called, the crisis of social reproduction.

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[1] UNISON's Ethical Care Charter (ECC) was launched in 2012 and called for councils to sign up to becoming Ethical Care Councils by commissioning homecare services which establish: 'a minimum baseline for the safety, quality and dignity of care by ensuring employment conditions which a) do not routinely shortchange clients and b) ensure the recruitment and retention of a more stable workforce

through more sustainable pay, conditions and training levels'. By 2016 15 Councils and care providers had adopted the Charter.

[2] Now the National Living Wage, introduced by the UK Government in April 2016.

[3] Whilst UNISON has mounted a successful legal challenge to the non-payment of travel time (Whittlestone vBJP Home Support Limited UKEAT/0128/13/BA, 2013) which was recognised as 'time work', evidence from the case studies presented here suggest that local authority charge rates cannot always accommodate such costs.

[4] The Living Wage is an independently-calculated wage rate based on what employees and their families need to live on, the rate is higher for London and both the Living Wage and London Living Wage are above the Government's National Living Wage.

[5] http://www.theguardian.com/business/2015/dec/09/how-sports-direct-effectively-pays-below-minimum-wage-pay