

The role of voluntary organisations in promoting carers’ work-care reconciliation: a case study of the CReate project

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Abstract

This thesis examines the specific role voluntary organisations can play in promoting carers’ work-care reconciliation. It uses an in-depth longitudinal case study of a work-care reconciliation project delivered by a voluntary organisation to investigate how an organisation implemented support services for carers in practice, the challenges they faced, and the successes they achieved. An ethic of care framework informs the thesis and analysis focuses on relationships and social processes. Using evidence from the case study, it is argued that voluntary organisations can promote carers’ work-care reconciliation by ‘delivering person-centred support’ and contributing to ‘creating carer-friendly workplaces’. It is suggested that, ultimately, the moral and political principals of ‘an ethic of care’ are important for understanding *how* voluntary organisations can support the work-care reconciliation of carers and the concept ‘civil society’ helps us understand *why* they can promote carers’ work-care reconciliation in practice.

The challenges to sustainability voluntary organisations providing work-care reconciliation support face and changes within civil society, however, appear to threaten the ability of organisations to deliver services in line with an ethic of care and so promote carers’ work-care reconciliation. The thesis contributes to debates regarding how carers can be supported to combine work and care and the changing role of voluntary organisations in society and makes three principal original contributions to knowledge: it presents evidence from longitudinal research into the specific role voluntary organisations can play in promoting carers’ work-care reconciliation, it develops a theoretical understanding of the role voluntary organisations can play and it provides insight into the specific challenges voluntary organisations delivering work-care reconciliation support can face and how they can be negotiated in practice, over time.

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# Chapter One: Introduction

## Thesis Overview

The thesis seeks to provide unique insight into the specific role voluntary organisations can play in promoting carers’ work-care reconciliation. Although there is no one definition of a ‘carer’ (Clements 2011), a carer in the thesis refers to: ‘someone who, *without payment*, provides help and support to a friend, neighbour, or relative, who could not manage otherwise because of frailness, illness, or disability’ (Carers’ Resource 2018a)[[1]](#footnote-1). The thesis presents evidence of how a well-established voluntary organisation implemented a work-care reconciliation project, the impact it had for beneficiaries, and the challenges it faced. It explores the relationships and social processes important for understanding the role voluntary organisations can play in promoting carers’ work-care reconciliation to make original contributions to knowledge. The thesis also examines the challenges to sustainability voluntary organisations providing work-care reconciliation support can face, and how organisations can negotiate these challenges in practice, over time. To do so, an in-depth longitudinal case study of a work-care reconciliation project delivered by a voluntary organisation is undertaken.

With an ageing population and increasing numbers of people in the UK living with disabilities and long-term conditions, the number of people providing unpaid care, and combining work and care, is set to significantly increase (Evandrou et al 2015; Carers UK 2014). At the same time, successive governments have promoted ‘full employment’, and have viewed work as the best form of welfare (Patrick 2012; DWP 2007; Lister 2001). Consequently, policy debates regarding how to support carers to combine work and care, or return to work, have emerged (HM Government 2010, 2008; HoCSC 2008). Some provisions for carers of working age are available through the welfare state or enshrined in law (Kröger and Yeandle 2013), outlined in Table 1.1.

Table 1.1 Development of policy and legislation regarding carers of working age

|  |  |  |
| --- | --- | --- |
| **Year** | **Policy/Legislation** | **Provisions for carers** |
| **1976** | **Invalid Care Allowance (ICA)** | Introduced the first benefit for carers, but only for unmarried people. Renamed ‘Carer’s Allowance’ in 2003.  |
| **1995** | **Carers (Recognition and Services) Act** | Gave carers who provide ‘substantial care on a regular basis’, the right to request an assessment from social services.  |
| **1999** | **National Carers’ Strategy** | Carers recognised in policy for first time. Emphasises the importance of working for many carers and supporting carers to combine work and care.  |
| **1999** | **Employment Relations Act**  | Gave employees the right to take a ‘reasonable amount’ of (unpaid) time off from work to deal with emergencies involving a dependent child or adult.  |
| **2000** | **Carers and Disabled Children Act** | Strengthened carers right to an assessment of their own needs |
| **2002** | **Employment Act** | Gave parents of disabled children the right to request flexible working  |
| **2004** | **Carers (Equal Opportunities) Act** | Further strengthened carers right to an assessment which must include carers wishes regarding employment, training and learning |
| **2006**  | **Work and Families Act** | Extended the right to request flexible working to most carers of adults |
| **2008** | **National Carers’ Strategy** | Emphasises the importance of supporting carers to combine work and care and pledged £38 million to support carers to combine work and care and re-enter the job market after their caring role through encouraging flexible working opportunities and increased training provision |
| **2010** | **National Carers’ Strategy** | Emphasises the importance of supporting carers to combine work and care and argues that the right to request flexible working should be extended to all.  |
| **2010** | **Equality Act** | Prevents carers from discrimination, including in the workplace, because they care for a disabled person.  |
| **2014** | **Children and Families Act** | Extends the right to request flexible working to all employees. |
| **2014** | **Carers Strategy: Second National Action Plan 2014-2016** | Outlines commitments to supporting carers for 2014-2016 including implementing and evaluating pilot employment support projects for carers, some delivered by voluntary organisations.  |
| **2014** | **Care Act** | Gives carers the legal right to have their needs assessed and receive support.  |

*Adapted from: Yeandle (2011)*

Governments have also increasingly looked to voluntary organisations to deliver services to tackle complex issues, such as an ageing population (Alcock 2010). A growing body of literature considers work-care reconciliation in the UK and previous research has considered: the experiences of carers combining work and care (Yeandle et al 2003; Dex and Scheibl 2002; Dex and Smith 2002;  Phillips et al 2002; Yeandle et al 2002); the support needs of carers of working age (Kröger and Yeandle 2013; Fetton and Mearns 2012; Vickerstaff et al 2009; Yeandle et al 2007b; Stiell et al 2006; Arksey et al 2005); the impact of combining work and care (King and Pickard, 2013; Carmichael et al 2010; Heitmueller 2007; Henz 2004; Evandrou and Glaser 2003); and carers’ experiences of policy and services in practice (Carers UK and Age UK 2016; van Wanrooy et al 2013; Tipping et al 2012; Larkin and Dickinson 2011; Glendinning and Kemp 2006; Ungerson 1997, 1995).

Although some research considers the role of voluntary organisations in promoting carers’ work-care reconciliation (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011a, 2011b; Vickerstaff et al 2009; Yeandle and Starr 2007; Formby and Yeandle 2005), the *specific* role voluntary organisations can play, remains under-researched. Previous research does not attempt to theorise the relationships important for understanding the role voluntary organisations can play in supporting carers’ work-care reconciliation, and longitudinal research is also lacking. Several authors raise sustainability as an issue facing voluntary organisations providing support to carers (Wigfield and Marangozov 2014; Yeandle et al 2011a, 2011b; Formby and Yeandle 2005; Arksey 2003), however, previous studies do not examine how organisations can negotiate sustainability in practice, over time. This thesis seeks to fill these gaps in the literature using the case study of the CReate project (a work-care reconciliation project delivered by a voluntary organisation) and further our understanding of the role voluntary organisations can play in promoting carers’ work-care reconciliation.

## Context and working definitions

6.5 million people in the UK provide unpaid care for someone because of old age, illness, or disability (ONS 2011). However, as many carers do not identify themselves as such, this number is thought to be significantly higher (Carers UK 2016a) and most people will be carers at some point during their life (Carers UK 2013). Three million carers (nearly half), combine paid work with care (ONS 2011). Two million carers are in full-time work and one million are in part-time employment (ONS 2011).  Although some provisions for carers of working age are now available (see Table 1.1), many still find it difficult to combine work and care, and some are forced to leave the labour market altogether (Carers UK 2016b).

1.4 million carers do not work (ONS 2011), and one in six give up work to care (Ipsos Mori 2009). Carers of working age provide the majority of care, and those aged 50-64 provide the highest share (ONS 2013a). Most carers of working age care for 1-19 hours a week, although the hours of care provided increases with age (ONS 2013a, 2013c). Women of working age provide more unpaid care than men, and 55% of carers combining work and care are women (ONS 2013a). Most carers in the UK are White British (Evandrou et al 2015; ONS 2013c), however, those who are Indian, Pakistani, or Bangladeshi, are more likely to provide care, and are also more likely to provide intensive amounts of care (over 50 hours a week) (Evandrou et al 2015; Yeandle et al 2007a). Carers of working age are more likely to report a decline in their health than the general population (ONS 2013d).

Voluntary organisations have been playing an increasing role in society, as successive governments have promoted their role in delivering public services and tackling complex issues (Rees and Mullins 2016; Pestoff et al 2012; Macmillan 2010; Osborne 2008; Brandsen and Pestoff 2006; Paxton et al 2005). In June 2016, there were approximately 163,000 voluntary organisations in the UK and 853,000 employees (2.7% of the total UK workforce) in the UK voluntary sector (Benard et al 2017). Income to voluntary organisations can be voluntary (including donations and grants from government) or earned (such as delivering contracts for government and private sector organisations or charging for services) (Benard et al 2017). Although voluntary sector income overall has increased in recent years, there has been a significant shift away from government grant funding to delivering public service contracts, illustrated in Figure 1.1 (Benard et al 2017; Crees et al, 2016). Governments since the early 1990s have looked to voluntary organisations to deliver services in a ‘mixed economy of welfare’ by ‘opening up’ service delivery to voluntary organisations and private companies, with the view that increased competition between providers would promote efficiency and greater choice (Macmillan 2010). More recently, governments and policy-makers have looked to voluntary organisations to promote notions of a ‘good society’ and ‘civic duty’ (Cameron 2010; Paxton et al 2005; Brown 2004).

Figure 1.1: Income of voluntary organisations from government contracts and grants 2000/01 to 2013/14 (£bn)



*Source: Crees et al (2016)*

Large and national organisations are the main recipients of individual donations and smaller and medium-sized organisations are often reliant on (now much scarcer) government funding (Crees et al 2016). Nearly 50% of organisations have an annual income under £10,000 and the vast majority (80%) receive under £100,000 a year (Crees et al 2016). Voluntary sector employees are primarily female, white, slightly older, and university educated (Benard et al 2017). 65% of the workforce is female, and only 9% of employees are from BAME groups (in comparison with 11% and 12% in the public and private sectors respectively) (Benard et al 2017). Voluntary sector staff are often highly qualified; nearly half (46%) have a university degree and only 2% have no qualifications (Crees et al 2016). Most employees are on permanent contracts (91%), although this is lower than the public and private sectors (93% and 95% respectively). A largeproportion of voluntary sector employees work part-time (38%), sometimes through choice, and sometimes due to the availability, or lack of availability, of funding (Crees et al 2016).

There has been much debate regarding the terminology used to describe the sphere between the market and state, and the organisations within it (Alcock 2010). Policy documents and previous research refer variously to: the voluntary sector; voluntary, community and faith sector; third sector; and civil society (Hilton and McKay 2011; Alcock 2010) (see Chapter 3, 3.2 for further discussion). Authors and policymakers have referred to the organisations as: voluntary organisations; voluntary and community organisations; third sector organisations; non-profits or NGOs (Non-Governmental Organisations); and civil society organisations (CSOs) (Milbourne 2013; Evers 2010; McLaughlin et al 2002). The thesis refers to ‘voluntary organisations’. Voluntary organisations are typically voluntary in nature, either through finance from grants and donations, the support of volunteers, or governance by trustees (Benard et al 2017). Historically and culturally, they are also independent of government and values-driven (impelled to promote social goals rather than to generate profit) (Evers and Laville 2004). ‘Voluntary sector’ in the thesis refers to the collection of voluntary organisations (Clark et al 2012).

The theoretical concept of ‘civil society’ (discussed further in Chapter 3) is used to help explain how voluntary organisations can promote carers’ work-care reconciliation. Following Edwards (2011), civil society is defined in the thesis in terms of ‘forms’, ‘norms’, and ‘space’. The forms of civil society include: voluntary organisations; co-operatives; housing associations; independent schools; and some employee-owned businesses and building societies (Benard et al 2017). Voluntary organisations, however, are at the heart of civil society (Benard et al 2017; Crees et al 2016). Civil society is also characterised by social norms, such as trust and reciprocity (Edwards 2011; Anheier and Kendall 2000; Edwards and Foley 1998). Civil society refers to the space between the market and state, where people can come together in associational life, and the marginal can challenge the powerful (Edwards 2011; Cohen and Arato 1994; Gramsci 1971; Habermas 1962). Figure 1.2 positions civil society and voluntary organisations in relation to the state, market, and family. Many argue, however, that the boundaries between spheres are becoming increasingly blurred (Civil Exchange 2016; The Baring Foundation 2014, 2013; Aiken and Bode 2009; Carmel and Harlock 2008; Wolch 1990). Civil society is used in the thesis as a Weberian ideal-type; as a conceptual tool (Keane 1998; Weber, 1947), to shed light on the role voluntary organisations can play in promoting carers’ work-care reconciliation.

Figure 1.2 Positioning civil society and voluntary organisations in relation to the state, market and family



*Adapted from Evers and Laville (2004)*

The definition of ‘work-care reconciliation’[[2]](#footnote-2) in the thesis stems from discussion on ‘work-life balance’. For some, work-life balance refers to the policies and institutional arrangements required to support people to manage the two spheres of work and home (Busby 2011; Lewis 2006). Others emphasise the importance of workplace practices (Bloom et al 2006; Rapoport et al 2002), and many focus on the socio-psychological impact for individuals combining multiple roles (Greenhaus and Powell 2006; Greenhaus et al 2003; Clark 2000; Kirchmeyer 2000; Marks and MacDermid 1996). These authors define work-life balance in relation to the macro, meso and micro levels of analysis. Most agree, however, that work-life balance is a dynamic social process, which shifts and changes over the life course (Greenhaus et al 2003; Rapoport et al 2002). This is the position taken in the thesis; work-care reconciliation refers to a dynamic social process which incorporates the macro, meso and micro. Work-care reconciliation, however, is also subjective and individuals have different experiences, and varying support needs, to combine work and care (Guest 2002; Nippert-Eng 1996).

## 1.3 Theoretical perspective

An ethic of care forms the ontological and epistemological positioning of the thesis. An ethic of care is a feminist perspective, which recognises the centrality of care and dependence to human existence (Tronto 2013, 1993; Held 2006; Williams 2001; Kittay 1999; Sevenhuijsen 1998). It contrasts with liberal ideas of social justice, which tend to view individuals as atomistic (see Rawls 1971). An ethic of care views care as a process and practice, underpinned by certain moral and political values (Tronto 2013, 1993; Williams 2002, 2001; Sevenhuijsen 1998). Tronto (2013, 1993) identifies four moral qualities important for an ethic of care: ‘attentiveness’, ‘responsibility’, ‘competence’ and ‘responsiveness’. These concepts relate to the four stages of caring which Tronto and Fisher (1990) outline: caring about, caring for, care-giving and care-receiving. Attentiveness relates to caring about, responsibility to caring for, competence to care-giving and responsiveness to care-receiving.

Attentiveness refers to recognition that some people in society are more vulnerable than others and need support (Tronto 1993). Responsibility refers to acting to provide this support (Tronto 1993). Competence relates to care-giving, and refers to the proficiency of actors providing care, as well as the appropriateness of that care (Tronto 1993). For care to be of good quality, the carer needs to understand how care is experienced by the care-receiver, although it is accepted that we can never fully comprehend what it is like to be someone else (Barnes, 2012; Sevenhuijsen 1998; Tronto 1993). Responsiveness refers to both the contribution of the care-receiver to the caring relationship, and the impact of care for the care-receiver (Tronto 1993).

An ethic of care is a political as well as moral concept (Williams 2002). According to Williams (2002), four political values underpin care: ‘mutualism’, ‘autonomy’, ‘inclusive diversity’, and ‘voice’. ‘Mutualism’ refers to recognition that we are interdependent, or necessarily dependent upon each other. This principle centres on ‘respect for the needs of others’ (Williams 2002, p.507). Autonomy in relation to an ethic of care does not equate to self-sufficiency but recognises that human capacity develops through relationships (Young 1997). ‘Inclusive diversity’ takes difference into account and acknowledges the heterogeneity of both carers, and caring relationships (Williams 2002). It recognises that social identity, such as gender and ethnicity, affect the experience of giving and receiving care (Williams 2002).

‘Voice’ refers to the extent services are organised and delivered around the needs and views of users of services (Williams 2002). In line with an ethic of care, it is important to analyse the relationships which promote carers’ work-care reconciliation and emphasise the voice of carers (Tronto 2013, 1993; Williams 2002). It is also essential to analyse all stages of the caring process (design, implementation, and impact of services), to be able to make assessments regarding the role voluntary organisations can play in promoting carers’ work-care reconciliation (Tronto 2013, 1993). The concept of ‘an ethic of care’ and how it is used in the thesis is examined further in Chapters 2 and 3.

## 1.4 Research Questions

To address gaps in the literature, the thesis considers three main research questions:

1. What role can voluntary organisations play in promoting carers’ work-care reconciliation?
2. How can voluntary organisations promote work-care reconciliation in a way which benefits both carers and employers?
3. What are the challenges to sustainability that voluntary organisations providing work-care reconciliation support can face? and how can organisations negotiate these challenges in practice, over time?

To address these research questions, the thesis presents evidence from a longitudinal case study of the CReate project (a work-care reconciliation project delivered by a voluntary organisation). The following sub-questions are examined through the case study:

* To what extent did the CReate project provide a support service from which both carers and employers benefitted?
* What were the characteristics of carers who accessed the project?
* What impact did carers’ involvement have on their decisions and behaviour regarding work and care?
* How were the design and implementation of the CReate project, and its outcomes, affected by the funding and public policy context within which it operated?
* Over the lifetime of the project, how and why did the relationships between CReate project staff and other organisations involved shift and change?

## ****1.5 The Research Journey****

The research in this thesis was undertaken using a constructivist grounded theory approach (see Chapter 4 for full discussion). Although the thesis is presented linearly (beginning with a review of the literature and followed by an outline of the methodology used and data analysis), the research process was inherently ‘messy’ and iterative. The thesis in its presentation and structure does not reflect the complexity of the research process. In line with a grounded theory approach, data was collected and analysed concurrently. An initial review of the literature was undertaken on the broad topics of carers of working age, work-care reconciliation and the changing role of the voluntary sector in the UK. As data collection and analysis progressed, concepts which emerged as important for explaining the role of voluntary organisations in promoting carers’ work-care reconciliation determined the direction of literature consulted. Partnership working, for example, emerged as an important concept early in the research process and so literature regarding partnership working in and with the voluntary sector was reviewed.

As data collection and analysis progressed and further important concepts emerged, literature was consulted alongside data collection and analysis to confirm or refute their utility in understanding the role of voluntary organisations in promoting carers’ work-care reconciliation. Although an ethic of care perspective informed the thesis ontologically and epistemologically, it wasn’t until later on in the research process that the importance of the individual moral and political principles of an ethic of care, and subsequently the relationship between an ethic of care and theories of civil society, became apparent. Once this link had emerged, subsequent data collection and literature reviewed sought to confirm or refute this conceptual framework. An iterative process of data collection, analysis and consulting the literature led to the conclusion that a combination of the moral and political principles of an ethic of care and theories of civil society provide the most comprehensive conceptual framework for understanding the role that voluntary organisations can play in promoting carers’ work-care reconciliation.

## 1.6 Thesis Structure

To answer the research questions, the thesis is structured as follows. Chapter 2 examines the ways work-care reconciliation has been conceptualised and theorised in policy and previous research, and the strengths and weaknesses of each approach. The chapter explores what is known regarding work-care reconciliation in the UK and identifies gaps in the literature to be examined in the thesis. It indicates that the concepts and theories used to examine work-care reconciliation in previous research are ‘role theory’, ‘border theory’, and the ‘commodification of care’. The chapter suggests, however, that these theories and concepts are insufficient in helping us understand the processes important for carers’ work-care reconciliation as they: focus on the individual rather than social relationships; are cross-sectional rather than longitudinal; do not consider civil society; and do not seek to challenge inequalities in relation to paid work and unpaid care. The chapter indicates that ‘creating carer-friendly workplaces’, ‘delivering person-centred support’, and ‘establishing an ethic of care’, are more useful concepts for understanding the processes which promote carers’ work-care reconciliation in practice. The chapter also considers the utility of longitudinal and mixed methods approaches for researching work-care reconciliation.

Chapter 3 examines previous research regarding the role of voluntary organisations in promoting carers’ work-care reconciliation and establishes further gaps in the literature to be examined in the thesis. It provides a conceptual framework for understanding the role voluntary organisations can play, and indicates that ‘policy implementation’, ‘partnership working’, ‘social inclusion’, and ‘sustainability’, are important concepts. The chapter examines and defines these concepts as they are used in the thesis. The chapter considers the role of ‘an ethic of care’ and ‘civil society’ in policy implementation, partnership working, social inclusion, and sustainability. It suggests that challenges to sustainability faced by voluntary organisations could jeopardise their ability to promote carers’ work-care reconciliation. The chapter demonstrates that although some previous research has considered the role of voluntary organisations in delivering programmes to support carers, the specific role voluntary organisations can play in promoting carers’ work-care reconciliation, over time, remains under-researched. It indicates that further research into how voluntary organisations providing work-care reconciliation support can negotiate sustainability in practice, would also be beneficial.

Chapter 4 outlines the methodology and research methods used to answer the research questions. It outlines the constructivist grounded theory and mixed methods approach used, and considers the longitudinal case study research design, and its strengths and weaknesses. The chapter discusses how tracking ten carers, semi-structured interviews, observation, and documentary analysis, were used to answer the research questions. It examines ethical issues in the research process, the ways these were addressed, and how reflexivity in the research process was achieved. Chapter 5 examines the CReate project, the case study used in the thesis. It positions the project within the context it operated in (Bradford), and in relation to Carers’ Resource, the voluntary organisation that delivered the project. It examines the aims, operational arrangements, and monitoring data, of the project. The chapter outlines: the services available through the CReate project; the staff that delivered services; the numbers and characteristics of carers and employers who accessed the project’s services; and CReate project monitoring data regarding their outcomes. It provides an overview of the case study used for the empirical research in the thesis and provides the foundations for the following empirical chapters.

Chapter 6 examines the specific role voluntary organisations can play in promoting carers’ work-care reconciliation (Research Question 1). It explores the design, implementation, and impact of the CReate project, and provides unique insight into how a voluntary organisation promoted work-care reconciliation, using longitudinal case studies. The chapter provides contemporaneous evidence regarding how CReate project staff implemented work-care reconciliation support in practice and examines to what extent the CReate project provided a support service which benefitted both carers and employers. It considers how the policy and funding context affected the design, implementation, and impact of the project and the extent to which the ways CReate project staff promoted carers’ work-care reconciliation can be interpreted using the concepts ‘delivering person-centred support’ and ‘creating carer-friendly workplaces’, outlined in Chapter 2.

Chapter 7 examines how voluntary organisations can promote work-care reconciliation in a way which benefits both carers and employers (Research Question 2), using the case study of the CReate project. It seeks to contribute to our theoretical understanding of the role that voluntary organisations can play in promoting carers’ work-care reconciliation. The chapter suggests that ‘policy implementation’, ‘partnership working’, and ‘social inclusion’ as defined in relation to an ethic of care (outlined in Chapter 3), are important for understanding how the CReate project promoted carers’ work-care reconciliation. It uses the concepts of ‘an ethic of care’ and ‘civil society’ (outlined in Chapters 1, 2 and 3) to explain how the CReate project implemented services, worked in partnership, and promoted social inclusion. It suggests that the norms, forms and space of civil society are conducive to implementing services in line with an ethic of care and so to promoting carers’ work-care reconciliation.

Chapter 8 provides insight into the specific challenges to sustainability voluntary organisations providing work-care reconciliation support can face, and how these can be negotiated in practice, over time (Research Question 3). It indicates that the main challenges the CReate project faced were: ‘securing funding’; ‘demonstrating impact’; and ‘recruiting and retaining staff’ (outlined in Chapter 3). The chapter suggests that CReate project staff negotiated these challenges by: ‘delivering publicly-funded services’; and using ‘strategic decoupling’ (also outlined in Chapter 3). The chapter considers the implications of these challenges, and the ways staff negotiated them, for the role of the CReate project in delivering services in line with an ethic of care and promoting carers’ work-care reconciliation.

Chapter 9 summarises the key findings of the thesis and highlights the contributions to knowledge the thesis makes. It considers the policy implications of the empirical research findings and makes suggestions regarding future avenues of research. Overall, the thesis demonstrates that voluntary organisations can promote carers’ work-care reconciliation by ‘delivering person-centred support’ and ‘creating carer-friendly workplaces’. It indicates that ‘policy implementation’, ‘partnership working’, and ‘social inclusion’, in relation to an ethic of care, are important for understanding the role voluntary organisations can play in promoting carers’ work-care reconciliation. The thesis suggests that the norms, forms, and space, of civil society are conducive to delivering services in line with an ethic of care and promoting carers’ work-care reconciliation. Challenges to sustainability voluntary organisations providing work-care reconciliation support face, however, may jeopardise their ability to deliver services in line with an ethic of care and promote carers’ work-care reconciliation.

# Chapter 2: Theorising work-care reconciliation

## 2.1 Introduction

The chapter examines how work-care reconciliation is theorised in existing research and policy documents. It outlines the theories and concepts used to examine work-care reconciliation, analyses their strengths and weaknesses, and develops the conceptual framework to be used in the thesis. The chapter seeks to establish what is known regarding work-care reconciliation, and where there are gaps in understanding. The chapter predominantly focuses its analysis of empirical work in the UK, as this is the context in which the study is situated. However, it draws on international studies, where appropriate, and the concepts and theories examined are derived from international literature.

The chapter is organised as follows. Section 2.2 examines the development of concepts in policy documents and previous research used to describe the act of combining work and care, and why ‘work-care reconciliation’ is referred to in the thesis. Section 2.3 explores ‘role theory’ and existing research regarding the challenges that carers face in combining work and care. It considers the role of creating ‘carer-friendly workplaces’ in promoting carers’ work-care reconciliation. Section 2.4 examines ‘boundary theory’, how and why carers manage work and care in certain ways, and the role ‘delivering person-centred support’ can play. Section 2.5 explores the concept of ‘commodification of care’ and the role of an ‘ethic of care’ in promoting carers’ work-care reconciliation. Section 2.6 summarises the main arguments of the chapter.

## 2.2 Conceptualisations of work-care reconciliation

Existing research and policy documents often describe the process of combining work and care as a ‘juggling act’, or in terms of ‘work-life balance’ (Bernard and Phillips 2007; DTI 2004, 2000; Phillips et al 2002; Merrill 1997). Authors refer to policies that aim to support those combining work and care as ‘family-friendly’ (Lewis and Campbell 2008; Dex and Smith 2002; Phillips et al 2002; Lewis 1997). This section outlines why ‘work-care reconciliation’ is a more appropriate concept to capture the process of combining work and care. During the late 1990s, combining work and family life became a policy priority in the UK (DTI 2000). Previous research, however, has predominantly focused on combining work and childcare, as opposed to combining work and caring for someone who is elderly, sick, or disabled (Kröger and Yeandle 2013). The ‘New Labour’ government (1997-2010) recognised the need to make work and family life more compatible to respond to several challenges, including the increasing participation of women in the labour market and perceived shift away from the male breadwinner model, in which men undertook paid work and women provided care (Daly 2011; Williams 2001; DTI 2000).

In 1998, the Government launched the National Childcare Strategy (DfE 1998) to assist working parents and the National Carers’ Strategy in 1999, which recognised the importance of supporting carers, including around work-care reconciliation (Department of Health (DH) 1999). The Government also signed up to European legislation regarding parental leave and in 2002 the Employment Act provided employees with children under the age of six or with disabled children under the age of eighteen, the right to request flexible working (see Chapter 1, Table 1.1). Research initially referred to these measures as ‘family-friendly’ (Lewis and Campbell 2008; Dex and Smith 2002; Phillips et al 2002; Lewis 1997). Family-friendly measures, however, are those that mainly enable women to combine work and childcare (Lewis et al 2007). Some also argue that as governments introduced policies in the UK without a specific focus on gender equality, they are not ‘friendly’ for women in practice and reinforce gendered divisions of paid work and unpaid care (Pascall 2012; Lewis et al 2007). According to Dex and Smith (2002), some employers introduced arrangements solely for their own benefit, such as retaining employees, rather than supporting families (Dex and Smith 2002).

Subsequently, the expression ‘work-life balance’ became widespread in both policy documents and research. New Labour launched their ‘work-life balance campaign’ in March 2000, and at the EU level, the Working Time Directive outlined workers’ rights to breaks, holidays and time away from work (DTI 2004, 2000). The DTI (Department of Trade and Industry) (2004, no page no.) define Work-Life Balance as: “adjusting work patterns so that… regardless of age, race or gender, everyone can find a rhythm to help them combine work with their other responsibilities or aspirations”. The concept of work-life balance is broader than ‘family-friendly’ and includes aspects such as leisure, as well as care, within ‘life’ (Eikhof et al 2007). According to Lewis et al (2007), however, placing unpaid care within ‘life’ does not capture its’ true nature or value. Although ‘work-life balance’ alludes to potential differences in terms of social characteristics, it does not incorporate a commitment to address inequalities or challenge gender norms in relation to paid work and unpaid care (Lewis et al 2007). Burke (2004) states that ‘work-life balance’ also implies that responsibility to combine work and care lies with the individual. Similarly, authors often define combining work and care as a ‘juggling act’ (Bernard and Phillips 2007; Phillips et al 2002; Merrill 1997), which, again, suggests it is the responsibility of the carer to manage their work and care responsibilities, and does not incorporate a sense of the challenges involved in doing so.

More recently, unpaid carers of those who are sick, elderly or disabled have received some policy attention, including in relation to combining work and care (see Chapter 1, Table 1.1). The National Carers’ Strategies (HM Government 2010, 2008) recognise the importance of supporting carers to combine work and care and some modest provisions for carers of working age are now available through legislation or the welfare state. Research increasingly refers to ‘work-care reconciliation’ (Kröger and Yeandle 2013; Hamblin and Hoff 2012). According to Masselot and di Torella (2010), the concept ‘work-care reconciliation’ incorporates a sense of friction between the two spheres of work and care and is neutral regarding where responsibility to manage work and care lies. Work-care reconciliation is also used by EU policymakers and distinctly incorporates a commitment to gender equality (Masselot and di Torella 2010; European Commission 2009). According to the European Court of Justice, ‘reconciliation is the natural corollary to gender equality’ (ECR 1998, para. 42). Work-care reconciliation is the most appropriate term to capture the process of combining work and care, in all its complexity, and is the term used in the thesis.

## 2.3 Creating carer-friendly workplaces

Work-care reconciliation is often theorised in terms of role theory, role stress and care burden. According to role theory, the two spheres of work and family can conflict as they place competing demands on an individual (Biddle 1986; Goode 1960). Carers face difficulty combining work and care if one, or both, roles, become too demanding. This perspective seeks to explain why carers often find it challenging to combine work and care and emphasises the negative impact that caring can have on work and vice versa (Biddle 1979). In line with this perspective, the National Carers’ Strategies (HM Government 2010, 2008) recognise that carers often face difficulty combining work and care and highlight the negative impact caring can have on employment, education, training, and financial circumstances. The 2008 Strategy emphasises the importance of supporting carers to alleviate role stress and states, “we agree wholeheartedly with the ambition to help carers manage the balance between caring and work” (HM Government 2008, p.90).

Several authors examine the impact of care on work and vice versa, and the factors which cause role stress (King and Pickard 2013; Michaud et al 2010; Heitmueller 2007; Henz 2004; Phillips et al 2002; Yeandle et al 2002). Secondary quantitative analysis suggests caring for ten or more hours per week and being a co-resident carer causes role stress (King and Pickard 2013; Leigh 2010; Michaud et al 2010; Young and Grundy 2008; Heitmueller 2007; Henz 2004). Initially, however, it was thought that caring for 20 hours a week or more negatively impacts employment (Leigh 2010; Michaud et al 2010; Young and Grundy 2008; Heitmueller 2007; Henz 2004). According to Henz’ (2004) longitudinal analysis of the Family and Working Lives Survey (FWLS) (1994-5), those caring for 20 hours or more per week and those who are co-resident carers are more likely to leave the labour market. Similarly, Heitmueller (2007) argues that only those caring for over 20 hours per week and co-resident carers experience a negative impact of caring on labour market participation. Heitmueller’s (2007) analysis of 12 waves of the British Household Panel Survey (BHPS) (1991-2002) also indicates that those who are out of the labour market are more likely to take on caring responsibilities.

Using more recent data, (the English Longitudinal Study of Ageing, 2002-2009), King and Pickard (2013) test the hypothesis that providing ten hours or more of care per week has a negative impact on labour market participation and conclude that it does. These studies emphasise the importance of a longitudinal perspective when examining the relationship between work and care, as it shifts and changes over the life-course (King and Pickard 2013) and a longitudinal perspective will be adopted in the thesis. These authors (King and Pickard 2013; Leigh 2010; Michaud et al 2010; Young and Grundy 2008; Heitmueller 2007; Henz 2004), however, define a ‘negative impact’ in terms of leaving the labour market, whereas for most carers, leaving the labour market is the last resort (Yeandle et al 2007b). Secondary quantitative analysis regarding the factors that cause role stress is also limited to the variables available within data and does not include the experiences or voices of carers.

A significant body of research regarding carers in employment was undertaken within JRF’s Work and Family Life programme (Yeandle et al 2003; Dex and Scheibl 2002; Dex and Smith 2002; Phillips et al 2002; Yeandle et al 2002). Empirical research regarding the challenges that carers face in achieving work-care reconciliation identified several further causes of role stress, including: carers’ health; a lack of flexible working provision; ‘organisational culture’; ‘sandwich caring’; ‘caring at a distance’; and the inability to deal with emergencies (Phillips et al 2002; Yeandle et al 2002). Carers interviewed and carer questionnaire responses in Phillips et al’s (2002) comprehensive study of carers in employment, indicated that carers’ own health was the principal source of role stress. Carers reported feeling worn out, which affected their ability to carry out their work and caring roles (Phillips et al 2002). Carers often experience decreased health because of caring responsibilities (Carers UK 2004; Hirst 2004). For a few carers interviewed in Phillips et al’s (2002) study, difficult family relationships impacted on their ability to combine work and care, and some found it difficult to manage travel time when those they cared for lived a significant distance away (Phillips et al 2002). ‘Caring at a distance’ is a particular challenge for work-care reconciliation, and the majority (90%) of carers in Employers for Carers’ study of caring at a distance[[3]](#footnote-3), reported that caring impacted on their capacity to work (EfC 2011). Nearly one quarter (23%) had changed their working pattern to care and some had reduced their hours (14%) or taken a less senior role (10%) (EfC 2011). Those caring for someone living close by, however, were not included as a point of comparison (EfC 2011).

Those caring for both older parents and children also experienced particular difficulty combining work and care (Phillips et al 2002). Indeed, ‘sandwich carers’, as they are now referred to, often find it more challenging than other carers to combine work and care as they experience multiple role stress (Ben-Galim and Silim 2013; Carers UK and EfC 2011). According to Yeandle et al (2002), those caring for both children and older parents are more likely to report a negative impact of work-care reconciliation than other carers. Carers in Phillips et al’s (2002) study also suggested that a long-hours culture in the workplace was a major source of conflict, although most carers felt that their line manager and other colleagues were supportive. Carers in focus groups and questionnaire responses in Yeandle et al’s (2002) mixed methods study, reported that workload pressures, service demands and the extent to which the line manager was supportive, impacted work-care reconciliation. Those who worked in smaller organisations experienced particular difficulty in managing their workload (Yeandle et al 2002). For carers in Yeandle et al’s (2002) study, however, the inability to respond to emergencies and unpredictable events was the major source of stress. These studies (Phillips et al 2002 and Yeandle et al 2002) emphasise the utility of a mixed methods approach to examining work-care reconciliation as it enables a nuanced view of carers’ experiences to be developed.

These authors (Phillips et al 2002 and Yeandle et al 2002) and Arksey (2002) also examine the workplace factors that promote carers’ work-care reconciliation and limit role stress. Carers identified several helpful workplace practices, including: a supportive line manager; supportive colleagues; information regarding support available; policies such as carers’ leave and flexible working; access to the telephone; longer lunch breaks; and being able to leave on time (Arksey 2002; Phillips et al 2002; Yeandle et al 2002). Carers, however, identified a supportive line manager as the most important factor for work-care reconciliation and reducing role stress (Arksey 2002; Phillips 2002; Yeandle et al 2002). Managerial discretion was essential for carers in Yeandle et al’s (2002) study, and Phillips et al (2002, p22) state, ‘the importance of a supportive manager cannot be underestimated’. Several other authors emphasise the importance of the line manager in promoting carers’ work-care reconciliation and implementing work-care reconciliation policies in practice (Hamblin and Hoff 2012; McCarthy et al 2010; Hegewisch 2009; Higgins et al 2008; Yeandle et al 2003; Glynn et al 2002; Yeandle et al 2002; Lewis 1997). Consequently, Yeandle et al (2003) deem training for line managers on supporting carers in the workplace essential, something which is explored further in Chapter 6.

Workplace support available for participant carers in the JRF study included measures such as: flexible working; part-time working; flexi-time; home working; annualised hours; term-time working; carers’ leave (paid or unpaid); and time off in emergencies (Yeandle et al 2003; Dex and Scheibl 2002; Dex and Smith 2002; Yeandle et al 2002). It is important to note that workplace support here does not refer to statutory support, such as the right to request flexible working (introduced for parent carers in 2002, carers in 2006, and all employees in 2014), but to policies available through individual organisations[[4]](#footnote-4). Evidence from previous research indicates that the availability of workplace support varies from employer to employer and is often implemented on an informal and ad hoc basis (Yeandle et al 2003; Dex and Scheibl 2002; Dex and Smith 2002; Yeandle et al 2002). According to Dex and Smith (2002), flexible working policies are more common in organisations: in the public sector, which have a high proportion of female employees, that recognise unions, have lower degrees of competition, and have committed managers and strong equal opportunities in place. Undertaking secondary quantitative analysis of the 1998 WERS (Workplace Employment Relations Study) enabled the correlation between flexible working policies and organisational characteristics to be established (Dex and Smith 2002).

Empirical research into the availability of, and carers’ and line managers’ experiences of, work-care reconciliation policies indicates that several further factors determine the implementation of policies in practice (Yeandle et al 2003; Dex and Scheibl 2002, 1998; Yeandle et al 2002). Line managers interviewed in Yeandle et al’s (2002) study indicated that implementation is determined by: the line manager’s discretion; training and guidance; concerns regarding the potential for abuse; consultation and communication; and service provision and delivery (Yeandle et al 2002). Evidence from Yeandle et al’s (2003) study, which included interviews with over 90 line managers in twenty different organisational settings, indicated that whilst some managers are ‘progressive’, others are ‘ignorant’ of, or ‘resistant’ to, implementing work-care reconciliation policies (Yeandle et al 2003). The majority had limited knowledge of policies available, and implementation was often on an ad hoc basis (Yeandle et al 2003). Evidence from these studies suggests, however, that line managers with experience of caring responsibilities themselves are often more likely to support carers in the workplace (Yeandle et al 2003; Yeandle et al 2002).

Dex and Scheibl (2002, 1998) demonstrate that organisations also face internal and external barriers to implementing workplace flexibility in practice. Their study into how SMEs (small and medium-sized enterprises) can be supported to implement work-care reconciliation policies revealed several barriers, including: perceived negative business impact; organisational culture; constraints due to the size of an organisation; local labour market conditions; and the social policy environment (Dex and Scheibl (2002, 1998). Carers are often not aware of provisions available (Yeandle et al 2002). In Yeandle et al’s (2002) study, only half of employee respondents were aware of provisions available, although all four organisations included had a range of work-care reconciliation policies available.

Evidence from these studies suggest that creating a ‘carer-friendly workplace’ is essential for carers’ work-care reconciliation. Organisations such as Employers for Carers[[5]](#footnote-5) have been campaigning and working with employers to create ‘carer-friendly workplaces’. Building ‘carer-friendly communities’ has become a key aim for Carers Week, which runs annually to raise awareness of the issues that carers face and provide recognition to unpaid carers (Carers Week 2016). According to Carers Week (2016 p.4), carer-friendly communities are:

“Places where local people and services support carers to look after their loved ones well, while recognising that they are individuals with needs of their own. For example, a GP service might offer carers flexible appointment times around their caring responsibilities, or an employer might offer flexible working hours to carers…...They have some understanding of a carer’s daily reality, recognising that they are often under a lot of pressure and tend to be hidden from view”.

Drawing on this definition, a carer-friendly workplace is one that identifies and recognises carers in the workplace, understands the challenges that carers often face, and provides support for carers to undertake care and remain in employment. Several authors argue that a supportive organisational culture is important for creating a carer-friendly workplace (Callan 2007; Lewis and Cooper 2005; Rapoport et al 2002; Lewis 1997) and, as previously outlined, support from the line manager is essential for promoting carers’ work-care reconciliation (Yeandle et al 2003; Arksey 2002; Phillips et al 2002; Yeandle et al 2002).

Some international research also emphasises the importance of ‘caring organisations’ in work-care reconciliation (Plaisier et al 2015). Plaisier et al (2015), for example, studied 50 Dutch organisations and undertook a survey of over 1,000 carers in employment. They concluded that the use of formal policies such as flexible working was not associated with better work-care reconciliation, but that organisational support was essential (Plaisier et al 2015). Following Hatch (1993), organisational culture is a dynamic social process that exists simultaneously on three levels; artefacts, values and basic assumptions. Hatch (1993) builds on Schein’s (1985) initial seminal model of organisational culture in which artefacts refer to the surface of the organisation and the visible factors such as structure and logos, values relate to the philosophy and standards of an organisation, and assumptions correspond to unconscious behaviour of those within an organisation. This initial model, however, was static in nature and Hatch (1993) emphasises the ongoing social processes of each layer of organisational culture.

Without access to appropriate workplace support, however, many carers experience role stress, and struggle to combine work and care. Several authors emphasise the negative impact that caring can have on employment and consequently, carers’ earnings, pensions, training, social exclusion, health, and self-esteem (Carers UK 2014; Carmichael et al 2010; Evandrou and Glaser 2003; Howard 2001; Holzhausen and Pearlman, 2000; Glendinning 1992). According to Holzhausen and Pearlman (2000), many carers who provide substantial amounts of care (defined as 20 hours or more per week) live on the breadline, which is partly due to carers having to give up work to care. In this study, 59% of carers from a national survey indicated they had to give up work due to caring, which resulted in a substantial drop of income (Holzhausen and Pearlman 2000). Black British and European carers were also more likely to have given up work to provide care (Holzhausen and Pearlman 2000). Similarly, according to Howard (2001), carers of working age who have to give up work to care, can experience financial difficulty and are more vulnerable to social exclusion.

Evandrou and Glaser (2003) argue that in comparison with non-carers, carers who have left the labour market to care have lower pension incomes in later life due to foregone earnings. Their secondary analysis of the British Family and Working Lives Survey (1994/5) indicated that 20% of women with caring responsibilities left the labour market to care and a further 20% reported they worked fewer or restricted hours or earned less money because of caring. Those who had stopped work were less likely to be members of an occupational pension scheme, and had accrued fewer years of pension contributions, than non-carers and those who combined work and care (Evandrou and Glaser 2003). More recently, Carmichael et al (2010) considered the impact of caring responsibilities on women’s employment using a mixed methods approach. The majority of carers interviewed had given up work to care (19 out of 30), although the majority were also providing care for someone in their household, which often has a negative impact on employment (Heitmueller 2007; Henz 2004). Carers interviewed reported that, because of caring, they were often unable to pursue promotions, had restricted opportunities in employment, and some had foregone earnings. Others on low incomes reported they found themselves in a ‘benefits trap’, as an increase in working hours would result in a loss of benefits (Carmichael et al 2010).

Similarly, respondents in Carers UK’s (2014) Caring and Family Finances Inquiry, which included evidence from a survey of nearly 4,000 carers, reported that role stress from work-care reconciliation could lead to absence from work, tiredness and underperformance, as well as high levels of stress. Many carers who participated in evidence sessions had to reduce their working hours or undertake lower skilled work that was more flexible to their needs (Carers UK 2014). Carers experienced a significant negative impact on their income and 30% reported they received £20,000 a year less than previously (Carers UK 2014). Women were more likely than their male counterparts to have changed their working hours or left employment. Carers who had left the labour market reported a loss of confidence, skills and knowledge. Ill health was also a significant barrier to returning to employment (Carers UK 2014). Carers out of the labour market for a significant period often feel that their skills are out of date and wish to undertake training before returning to the labour market (HoCSC 2008). Carers also often have decreased confidence and self-esteem (Aggar et al 2011; Colombo et al 2011; Maher and Green 2002). Role stress can have a significant negative impact for carers in relation to employment, and consequently, carers’ finances, pensions, health, confidence, and social exclusion.

On the other hand, there is considerable evidence regarding the benefits of work-care reconciliation, for carers themselves, as well as for businesses and the wider economy (Carers UK et al 2013; Age UK 2012; Yeandle et al 2006; Dex and Smith 2003; Bond et al 2002). Carers interviewed in Yeandle et al’s (2006) study of the social and business benefits of supporting carers in employment, reported several psycho-social benefits of combining work and care, such as a sense of self, improved confidence, and financial gains. Several authors emphasise the business benefits of supporting carers in employment, which include: increased productivity; greater staff retention; savings in recruitment costs; reduced sick leave; and a happier workforce (Carers UK et al 2013; Yeandle et al 2006; Crompton et al 2003; Dex and Smith 2003; Bond et al 2002). According to Age UK (2012), the public expenditure costs of carers leaving the labour market are £1.3 billion a year due to lost tax revenues, foregone incomes and Carer’s Allowance[[6]](#footnote-6) payments. They estimate that enabling carers to combine work and care could contribute up to £5.3 billion to the economy (Age UK 2012). Furthermore, although some carers are forced to leave the labour market to care, the majority of carers manage to combine the two (Kröger and Yeandle 2013).

The National Carers’ Strategies (HM Government 2010, 2008) outline the benefits of work-care reconciliation, as well as the issues. The 2008 Strategy states, “enabling carers to work not only helps them as individuals but also improves the efficiency of the labour market and helps to sustain growth in the economy” (HM Government 2008, p90).  The 2010 Strategy (HM Government 2010, p15) states:

“The Government wants to empower carers to fulfil their work potential, to protect their own and their family’s current and future financial position and to enjoy the health benefits and self-esteem that paid employment or self-employment can bring”.

Theories of role theory, role stress, and care burden have been used to theorise work-care reconciliation. Existing research considers the challenges that carers face combining work and care, and the negative impact that caring can have on work and vice versa. Role theory is useful in terms of illustrating why carers often face difficulty combining work and care and the negative impact caring can have on employment, but there are several limitations to this perspective. Role theory does not help us understand what promotes carers’ work-care reconciliation in practice. It is also cross-sectional rather than longitudinal and explains why carers may face difficulty combining work and care at specific points in time but does not take time and change into account (Phillips 2002). Carers also do not possess agency as authors emphasise the challenges carers face, not the strategies carers use to combine work and care[[7]](#footnote-7). Furthermore, role theory focuses on the individual, rather than relationships. Role theory conceptualises work-care reconciliation as a relationship between the two (competing) spheres of work and family and does not consider the role of the state or civil society. Consequently, ‘creating carer-friendly workplaces’ is a more useful concept for understanding what promotes carers’ work-care reconciliation in practice.

This concept can challenge traditional gender roles in relation to paid work and unpaid care, as Lewis and Taylor (1996) argue, deep-rooted beliefs and societal norms regarding gender and work are reflected in and perpetuated by organisational culture, and so it is here that assumptions can be challenged (although this is often difficult to achieve) (Rapoport et al 2002; Lewis and Taylor 1996).‘Creating a carer-friendly workplace’ does not restrict the conceptualisation of work-care reconciliation to a relationship between the market and family; the state and civil society can also play a role. As a dynamic social process, the concept considers time and change and consequently, creating a carer-friendly workplace is more appropriate than role theory for understanding the processes that promote carers’ work-care reconciliation in practice, and is the concept used in the thesis.

## 2.4 Delivering person-centred support

Work-care reconciliation is also often theorised in terms of boundary, or border theory. Boundary theory seeks to explain how and why people manage the competing demands of work and family in particular ways (Ashforth et al 2000; Clark 2000; Nippert-Eng 1996). According to this perspective, people manage work and family in relation to the boundaries of time, space, and place, as well as psychological boundaries (Nippert-Eng 1996).  Consequently, according to Clark (2000 p747), we are all ‘daily border-crossers’. Integration and segmentation are at opposite ends of the spectrum in relation to how people manage work and family (Clark 2000), and boundary and border theories describe the conditions under which integration or segmentation are likely to enhance or diminish well-being (Desrochers and Sargent 2004). In practice, Nippert-Eng’s (1996) study of how people manage work and home found that some people favour integration whereas others favour segmentation. Clark (2000) seeks to test boundary theory and suggests that high flexibility and low permeability of boundaries is most appropriate for work-care reconciliation. Clark, however, also states that ‘in actuality, there is no one desirable state of integration or segmentation’ (Clark, 2000, p.755).

The National Carers’ Strategies (HM Government 2010, 2008) emphasise the importance of supporting carers to combine work and care, and some provisions that support carers to manage the boundaries of work and care are now available through the state (see Chapter 1, Table 1.1). The main provisions outlined in policy are flexible working and employment support through Jobcentre Plus (HM Government 2010, 2008). Civil society is not conceptualised as playing a role, although the National Carers’ Strategies state they will investigate the feasibility of voluntary organisations delivering employment support. Some qualitative studies examine the factors that influence carers’ decision-making regarding work and care (Vickerstaff et al 2009; Arksey et al 2005; Mooney et al 2002). The principal factors carers identified include: financial considerations; attachment to work; workplace support; social care services; carers’ own health; and the nature of and commitment to caring responsibilities (Vickerstaff et al 2009; Arksey et al 2005; Mooney et al 2002). A boundary theory perspective recognises that carers have agency and make active decisions regarding work and care, in contrast to the role stress perspective.

For carers interviewed in Mooney et al’s (2002) study regarding work-care reconciliation after 50, the financial implications of leaving the labour market, and whether they could afford to do so, were primary considerations. Attachment to work was also important, including whether they were stressed at work, and the extent they enjoyed their job. Appropriate support for both the carer and care recipient were also necessary (Mooney et al 2002). Arksey et al (2005) included carers aged between 16 and statutory pension age in their study of carers’ aspirations and decision-making regarding work, care and pensions. They also sought to include a representative sample in terms of gender, ethnicity, relationship to the cared-for and location, although as a qualitative study, it was not statistically representative. Carers, again, emphasised the importance of financial circumstances, commitment to their job, and availability of informal and formal support services. However, carers’ own health, personal attitudes towards work, and factors related to the care recipient and their support needs, were also important. For rural carers, distance and travel times were important for work-care reconciliation. Carers in Vickerstaff et al’s (2009) qualitative study emphasised the positive attributes of work as the principal factor that influenced their decision-making regarding work and care. Carers interviewed felt that work was a way to escape the stress of caring and was somewhere they felt appreciated. Carers also highly valued the social aspect of work and the intellectual stimulation it brought (Vickerstaff et al 2009).

Evidence from existing research indicates that carers use a variety of strategies to combine work and care, including: informal and formal workplace support; support from family and friends; social care services; Jobcentre Plus support; and carer centre support (Kröger and Yeandle 2013; Fetton and Mearns 2012; Vickerstaff et al 2009; Yeandle et al 2007b; Stiell et al 2006; Arksey et al 2005). Previous research suggests, however, that carers often manage work and care themselves, or by using informal workplace support and support from family and friends, rather than accessing formal provisions such as the right to request flexible working, social care services, or Jobcentre Plus support (Carers UK and Age UK 2016; Kröger and Yeandle 2013; van Wanrooy et al 2013; Fetton and Mearns 2012; Tipping et al 2012; Pritchard 2011; Vickerstaff et al 2009; Yeandle et al 2007b; Stiell et al 2006; Arksey et al 2005).

Carers interviewed in Arksey et al’s (2005) large-scale qualitative study often managed work and care themselves without accessing support or preferred to use informal support in the workplace. Similarly, most carers in Vickerstaff et al’s (2009) qualitative study of the employment support needs of carers relied on the support of family and friends or managed work and care themselves. These experiences echo those of carers in Yeandle et al’s (2007) comprehensive mixed methods study into the services carers use to manage work and care. Most (75%) carers in employment in this study had support from friends and family that enabled them to manage the boundaries of work and care. Parent carers interviewed in Stiell et al’s (2006) study also relied considerably on support from family or friends.

Evidence regarding carers’ experiences and the implementation of statutory support services (right to request flexible working, time off for dependents, social care services and Jobcentre Plus support) suggests they are often not adequate, or appropriate, for enabling carers’ work-care reconciliation (Carers UK and Age UK 2016; van Wanrooy et al 2013; Tipping et al 2012; Pritchard 2011; Vickerstaff et al 2009; Arksey et al 2005). Previous research indicates that carers often prefer to access informal workplace support rather than formal policies such as the right to request flexible working (Carers UK and Age UK 2016; van Wanrooy et al 2013; Tipping et al 2012; Vickerstaff et al 2009; Arksey et al 2005). Flexible working is conceptualised in policy as one of the principal means by which carers can manage the boundaries of work and care (HM Government 2010, 2008) and as enshrined in law (Children and Families Act, 2014), all employees now have the right to request flexible working, although some carers have had this right since 2006 under the Work and Families Act[[8]](#footnote-8). Under the Employment Rights Act (1999), all employees can also take time off for dependents in emergencies, although this is unpaid.

Quantitative evidence regarding awareness and uptake of flexible working policies indicates that carers are more aware than other employees of the right to request flexible working, more likely to be working flexibly and have taken time off for dependents, however, still often face difficulty combining work and care (Van Wanrooy et al 2013; Tipping et al 2012). Analysis of evidence from the 2011 WERS (Work, Employment Relations Study)[[9]](#footnote-9) indicates that carers accessed flexitime (33%), working from home (20%), paid time off in emergency (18%), reduced hours (12%), compressed hours (9%), term time working (9%) and job share (5%) (van Wanrooy et al 2013). Multivariate analysis of the Fourth Work-Life Balance employee survey, which collates national evidence regarding the awareness and uptake of work-care reconciliation policies, indicates that carers most commonly used flexitime (53%) and part-time work (42%). Nevertheless, carers were still more likely to report that ‘work interfered with life outside work’ in comparison with other employees (30% in comparison with 25%) (van Wanrooy et al 2013). Part-time work is also often associated with low-paid, low-skilled work (Grant et al 2005) and women and those aged 16-39 were much more likely to be working part-time than others (50% of female carers worked part-time in comparison with 36% of male carers) (Tipping et al 2012).

Furthermore, evidence from the Fourth Work-Life Balance Employer Survey (2014) indicates that men are less likely to make a request for flexible working and are more likely to have their requests rejected (BIS 2014). 65% of organisations included in the study had not received any requests from men in the 12 months the research covered, and the majority of requests that were rejected (75%), were from men (BIS 2014). Without changes to organisational culture, policies such as flexible working may uphold gender norms in relation to paid work and unpaid care. These studies, however, were undertaken before the Coalition government extended the right to request flexible working to all in 2014, which may help normalise flexible working. Qualitative evidence regarding carers’ experiences of flexible working policies in practice suggest that carers are often not aware of their rights in the workplace but are also reluctant to make formal requests (Carers UK and Age UK 2016; Fetton and Mearns 2012; Vickerstaff et al 2009; Stiell et al 2006). Carers interviewed in Vickerstaff et al’s (2009) study identified workplace support and flexibility as essential for work-care reconciliation, however, few reported that their employer had formal carers’ or flexible working policies in place. Carers felt it was often up to them to request support, and the majority of carers interviewed were unaware of their rights in the workplace or did not wish to burden their employer with their problems (Vickerstaff et al 2009).

Similarly, carers who participated in focus groups in Carers UK and Age UK’s (2016) study of work-care reconciliation in later life, felt that a lack of flexibility was the greatest barrier to remaining in employment. Some carers reported they had had their requests rejected and others did not feel able to ask their employer or assumed their employer would reject their request. Several carers, however, were unaware of their rights around flexible working (Carers UK and Age UK 2016). The majority of parent carers in Stiell et al’s (2006) longitudinal study of the experiences of combining work and care used part-time working and flexi-time to manage work and care. Several carers wished to work term-time only but had been unsuccessful in their requests. Carers expressed the need for further support and advice around negotiating flexible working (Stiell et al 2006). On the other hand, parent carers in Fetton and Mearns’ (2012) survey of over a thousand families with disabled children reported they often used annual leave to manage work and care, rather than accessing flexible working policies.

Evidence regarding Jobcentre Plus support indicates that few carers have accessed this support, and those who have, found it to be inadequate for their needs (Pritchard 2011; Vickerstaff et al 2009; Arksey et al 2005). According to the DWP (Department of Work and Pensions), Jobcentre Plus should provide employment support for carers through specialist trained providers, fund replacement care for those participating in approved training, and advertise flexible job vacancies (Pritchard 2011). In practice, however, analysis of the Labour Market System (LMS) and Work and Pensions Longitudinal Study (WPLS), which monitor the number of carers accessing carer support, indicated that by the end of 2011, only 6,620 carers had received support through the Jobcentre Plus scheme, introduced in December 2009 (Pritchard 2011). Furthermore, 70% of carers reported that support was not adequate for their needs (Pritchard 2011). Only a few carers (just over 25%) in Arksey et al’s (2005) study had accessed support through the Jobcentre and participated in a Work Focused Interview (WFI)[[10]](#footnote-10). Although those who had appreciated the advice and information received, as well as better-off-in-work calculations, carers found the Jobcentre environment intimidating and felt there was a lack of understanding from staff regarding the specific support needs of carers (Arksey et al 2005). Carers interviewed reported that WFIs had not affected their decisions regarding work and care. According to Jobcentre professionals who participated in focus groups, carers were not a priority in comparison with IB (Incapacity Benefit, now ESA, Employment and Support Allowance) claimants or disabled people, and they felt that the reputation of the Jobcentre discouraged carers from attending (Arksey et al 2005). Similarly, carers in Vickerstaff et al’s (2009) study felt that Jobcentre Plus services were not tailored to their needs and were delivered in an unwelcoming environment. Carers interviewed reported that Jobcentre staff did not have sufficient expertise regarding carers’ support needs and did not identify suitable jobs for carers (Vickerstaff et al 2009).

At the same time, evidence from existing research suggests that social care services for the care recipient are inadequate for promoting carers’ work-care reconciliation (Vickerstaff et al 2009; Yeandle et al 2007b; Arksey et al 2005). Carers interviewed in Arksey et al’s (2005) study often felt there was a lack of appropriate support available and insufficient information regarding services available. Parent carers in particular felt that a lack of appropriate care services was a major barrier to returning to work. Some carers were unwilling to accept support and did not trust social care services, whilst some care recipients were unwilling to accept support from others. The costs of services were also an issue (Arksey et al, 2005). Similarly, carers interviewed in Vickerstaff et al’s (2009) study felt that social care services were insufficient in enabling them to combine work and care, due to a lack of flexibility and accessibility. Carers reported that respite care in particular was difficult to access and often only provided in times of crisis (Vickerstaff et al 2009). Most carers in Yeandle et al’s (2007b) study (two-thirds of part-time employees and two-thirds of male full-time employees) reported they used at least one formal care service.

Home care, specialist nursing (often palliative care), mental health services, day centres and respite care were the services most commonly used. 75% of carers, however, did not feel that these services were adequate to enable them to combine work and care, and carers interviewed felt that services were not flexible or appropriate for their needs (Yeandle et al 2007b). Some also felt they were too expensive, and others did not access services as they wished to retain their privacy and independence. Those using Direct Payments, however, highly valued the flexibility in choosing support appropriate for them[[11]](#footnote-11) (Yeandle et al 2007b). Childcare is essential for parent carers’ work-care reconciliation (Fetton and Mearns, 2012; Stiell et al 2006). Carers of disabled children in Fetton and Mearns’ (2012) study identified childcare as the primary barrier to work-care reconciliation and felt that childcare available was not suitable for their needs, or not affordable. Furthermore, carers who completed the survey stated that statutory services often focus only on the needs of disabled children and not those of carers and the wider family (Fetton and Mearns 2012). Few parent carers interviewed in Stiell et al’s (2006) study were accessing social care services and carers viewed social services as a last resort. Parent carers identified a lack of appropriate childcare and school places as the greatest barrier to work-care reconciliation. Transport services and support during school holidays were also essential, but inadequate (Stiell et al 2006).

On the other hand, evidence from previous research indicates that carers often highly value the support offered through carers centres[[12]](#footnote-12), or voluntary organisations (Fetton and Mearns 2012; Vickerstaff et al 2009; Arksey et al 2005). Carers in Arksey et al’s (2005) study particularly valued counselling and listening services as well as advocacy services and access to breaks. Whilst these support services did not directly enable carers to combine work and care, they often reduced stress levels (Arksey et al 2005). Similarly, carers in Vickerstaff et al’s (2009) study highly valued the support available through voluntary organisations, especially the advice and information provided, and access to support groups. Carers also felt that voluntary sector staff had specialist knowledge, either regarding carers, or regarding specific conditions such as Alzheimer’s. As a result, carers often trusted voluntary sector staff, and reported support to be reliable and accessible (Vickerstaff et al 2009). Carers in employment, and those working full-time in particular, however, found it difficult to access carer centre services due to their office hours (usually 9-5) (Arksey et al 2005).

These studies indicate that several factors influence carers’ decision-making regarding work-care reconciliation, and carers manage the boundaries of work and care in different ways. Carers in these studies often managed work and care, however, using informal workplace support and support from family and friends, rather than accessing formal support services. This was often due to the perceived inadequacy of social care services and Jobcentre Plus support, as well as a lack of awareness of support available. Carers in these studies, however, highly valued the support offered through carers’ centres and voluntary organisations. Studies considered above emphasise the voice of carers and provide in-depth insight into carers’ experiences of work-care reconciliation. The majority of studies, however, are cross-sectional (with the exception of Stiell et al, 2006) and examine how carers manage work and care at a particular point in time whereas, as Hamblin and Hoff (2012) state, what suits carers at one point in time may not be suitable at another. These studies also do not consider the influence of the context on carers’ decision-making.

By undertaking international comparison of six countries with three different types of welfare state (Nordic, Liberal and East Asian), Kröger and Yeandle (2013) emphasise the importance of the context in decision-making regarding work and care. Although carers have agency and make active decisions, carers still make decisions within a particular structure, and culture. Kröger and Yeandle (2013) also emphasise the difference in strategies that carers use to combine work and care according to the caring relationship. They suggest that carers of older people often used flexible working, emergency leave and breaks or negotiated informal workplace arrangements, whereas parent carers use ‘cash-for-care’ schemes[[13]](#footnote-13) and rely on personal networks, childcare facilities and their employer (Kröger and Yeandle 2013).

Evidence from existing research indicates that in practice, a person-centred approach to support services promotes carers’ work-care reconciliation. A person-centred approach: values carers and treats carers as individuals, appreciating that carers all have a unique history, personality, and social and economic resources, and that these will affect their support needs and decision-making regarding work and care (WHO 2015; Dowling et al 2006; Stalker and Campbell 1998). It considers the world from the perspective of the carer and views carers as participants, as well as beneficiaries, of services (Brooker and Latham 2016; Parley 2001). A person-centred approach also recognises that care is grounded in relationships, takes a holistic approach to service delivery, and ensures that carers have the necessary information and support to make decisions regarding work and care (Beresford and Carr 2012; DH 2005).

Evidence from research examined here suggests that carers manage work and care in different ways and that an approach which considers all carers’ situations and personal preferences is required (Kröger and Yeandle 2013; Hamblin and Hoff, 2012; Vickerstaff et al, 2009; Yeandle et al, 2007b; Arksey et al, 2005). Carers interviewed in Hamblin and Hoff’s (2012) study, for example, when asked regarding the strategies they felt were most effective at enabling them to combine work and care, emphasised that each carer’s situation would be different, and the advice and support needed would have to be tailor-made. Furthermore, Yeandle et al (2007b, 2007c) emphasise that although caring is ubiquitous, carers have different experiences of caring and work-care reconciliation, according to their individual circumstances and preferences. Yeandle and Buckner (2007, p.28) conclude that nearly all carers want:

“…...sensitive, tailored support, designed with their own personal and working life, family circumstances, values and beliefs, in mind. This means that it is not so much ‘special’ services for ‘different’ groups which is needed…as that all carers need: better information, communicated to them effectively; more say in how services are designed and delivered to them and those they care for; respect and acknowledgement for their caring contribution from all the agencies and individuals they deal with; and to be treated as equal partners in the delivery of social care”.

A few authors seek to theorise the strategies carers use to manage work and care (Hamblin and Hoff 2012; Martin-Matthews and Phillips 2008; Hochschild 1997). Hochschild (1997) introduces the concept of the ‘time bind’ in her seminal study of employees at a Fortune 500 company and the ways in which they manage work and care. The ‘time bind’ refers to the phenomenon of work becoming home and home becoming work. Employees in her study increasingly viewed work as a haven and home as a source of stress, and consequently were spending increasing amounts of time at work, to manage work and care (Hochschild 1997). The boundaries between work and home had completely blurred so that the roles of work and home had switched. Martin-Matthews and Phillips (2008) use the lens of ‘boundaries’ to examine how carers manage work and home in an international context. They argue that some carers integrate work and care, whereas others segment the two spheres and suggest that the boundaries between work and home are becoming increasingly blurred. A critical perspective illuminates the strengths and weaknesses of policy and practice in relation to work and care, which will also be adopted in the thesis.

More recently, Hamblin and Hoff (2012) developed a typology according to the strategies carers use to manage work and care. They argue that some carers use formal care services and rely on family and friends, some make use of workplace arrangements available such as flexible working and time off for emergencies, others fit their caring responsibilities round their work, and some alter their working patterns to accommodate caring (Hamblin and Hoff 2012). Although the concepts developed in these studies are useful for theorising the ways carers manage work and care, they do not help us understand what promotes carers’ work-care reconciliation in practice.

Boundary theory is useful for examining how and why carers manage work and care in certain ways, at particular points in time. It recognises the agency of carers and the important role of the state and statutory support services. Boundary theory, however, has several limitations. It is a cross-sectional rather than longitudinal theory and explains how and why carers manage work and care at certain points in time. Boundary theory, as with role theory, also focuses on individuals and the strategies that individuals use to combine work and care, rather than relationships and interactions. Boundary theory does not challenge gender norms in relation to unpaid care and paid work and conceptualises work-care reconciliation as a relationship between the state, family and market. Civil society is not conceptualised as playing a role in work-care reconciliation, although some authors recognise the role of voluntary organisations in supporting carers and championing their rights (Kröger and Yeandle 2013; Vickerstaff et al, 2009; Arksey et al, 2005).

Although work-family border theory developed by Clark (2000) attempts to explain the conditions that enable people to combine work and home with minimum impact on their well-being, it seeks to develop a ‘one-size-fits-all’ approach to managing work and care. On the other hand, the concept ‘delivering person-centred support’ recognises that the situation and support needs of all carers are unique, and as an ongoing social process, can take time and change into account. It also focuses on the relationships and social interactions that promote carers’ work-care reconciliation. Person-centred support aims to empower people, and particularly those who are disadvantaged in society (DH, 2005; Parley, 2001) and can include the sphere of civil society. ‘Delivering person-centred support’ has a number of advantages over boundary theory for understanding what promotes carers’ work-care reconciliation in practice, and is the concept used in the thesis.

## 2.5 Establishing an ethic of care

Work-care reconciliation is also often theorised in terms of the ‘commodification of care’. The concept, first coined by Ungerson (1997), refers to the perceived ‘marketisation’ of social care, as individuals, including carers, become consumers of services. Research often refers to schemes that aim to provide cash payments, as either a wage or compensation, rather than prescribed care services, as ‘cash-for-care’ schemes (Ungerson and Yeandle 2007). Work-care reconciliation is realised either by remunerating carers to care or by freeing up carers so they can work (Ungerson 1997). The commodification of care perspective seeks to explain a shift in boundaries between the family, market and state, and the subsequent consequences for caring relationships (Ungerson and Yeandle 2007; Glendinning and Kemp 2006; Ungerson 1995).

The provision of cash to service users rather than prescribed services has been central to the development of social care policy in the UK, and in some other countries (Harlock 2009; Ungerson and Yeandle 2007; Glendinning and Kemp 2006). The provision of cash to service users is central to the ‘personalisation’ agenda[[14]](#footnote-14), which the New Labour government broadly defined as, “the way in which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive” (HM Government 2007, p33). The personalisation agenda aims to shift power away from the state, to communities and individuals, promote a plural market of service delivery, and provide service users with more choice and control over the services they receive (HM Government 2007).

Authors initially considered the development of cash-for-care schemes, the conceptual development of the ‘commodification of care’, and the implications of these schemes for the caring relationship (Ungerson and Yeandle 2007; Glendinning and Kemp 2006; Ungerson 1997, 1995; Evers et al 1994; Glendinning and McLaughlin 1993). The development of cash-for-care schemes in the late 1980s and 90s was an international phenomenon and authors identify several reasons for their development, including: broader changes in social policy; an ageing population; the level of care needed among the older population; the increasing number of very old people (85+); and a growth in pensioners’ incomes (Ungerson 1997; Evers et al 1994; Glendinning and McLaughlin 1993). According to Glendinning and McLaughlin (1993), the commodification of care in the UK reflected broader changes in social policy as ideas of New Public Management[[15]](#footnote-15) and Care in the Community[[16]](#footnote-16) became widespread, which sought to shift power away from the state. At the same time, the Independent Living Movement[[17]](#footnote-17) had been campaigning for years for the development of cash-for-care schemes to secure more choice and control over services for disabled people (Glendinning and McLaughlin 1993). According to Ungerson (1995), countries diversified their welfare services to deal with oncoming pressures relating to demographic changes and an ageing population. Governments viewed cash-for-care schemes as an effective, efficient way to provide support (Ungerson 1995).

More recently, Ungerson and Yeandle (2007) identify several further reasons for the development of these schemes, including the level of care needed among the older population, and a growth in pensioners’ incomes. Ungerson (1997, 1995) develops a conceptual typology of the types of payments for care that developed internationally:

1. Carer allowances paid through social security and tax systems
2. Wages paid by the state to the carer
3. Routed wages paid via direct payments to care users
4. Symbolic payments paid by care users to family, friends and neighbours who provide care
5. Paid volunteers who are paid by voluntary organisations and local authorities to provide care

Wages paid to the state by the carer and routed wages to the carer are the most relevant in the UK context, and examined in further detail subsequently. Although cash-for-care schemes aimed to provide greater choice and control over services and provide some recognition of the work that carers undertake, Ungerson (1997, 1995) draws attention to several potential issues relating to their implementation.  Empirically, she argues that the commodification of care could result in a ‘master and servant’ relationship (Ungerson 1995). She states that women are more likely to receive payments than men, which could ‘trap’ women in providing care (Ungerson 1995). Women are also most often in receipt of cash payments and more likely to forego employment to care (Ungerson 1995). Furthermore, she suggests that if cash-for-care schemes are unregulated with no minimum conditions or workers’ rights, they can lead to the social exclusion and exploitation of some groups in society, often women and migrant workers (Ungerson 1995).

Conceptually, Ungerson (1995) argues that cash-for-care payments could maintain the public/ private dichotomy as there is an assumption that those in the private domain, mostly women, are willing and able to provide care. In this sense, the commodification of care blurs the empirical boundaries between work and care and upholds the conceptual boundaries. Feminist authors, however, have long sought to dissolve the conceptual boundaries between work and care (Himmelweit 1995; Gardiner 1975; Oakley 1974). Glendinning and Kemp (2006) also argue that the commodification of care does not address gender inequalities in relation to paid and unpaid work and may perpetuate them in reality. They critically evaluate the development of cash-for-care schemes internationally and suggest that this is because women continue to undertake the majority of care work, and jobs in care work remain some of the lowest paid (Glendinning and Kemp 2006). An ethic of care, on the other hand, recognises the centrality of care to human existence and, as a feminist perspective, seeks to tackle gender inequality in relation to caring (Tronto 2013, 1993).

Existing research provides a useful overview of the development of cash-for-care schemes, the rationale behind their development, and raises potential issues with these schemes in practice (Ungerson 1997, 1995; Glendinning and McLaughlin 1993). These studies, however, do not include empirical research into the implementation of cash-for-care schemes or carers’ experiences of them in practice. Among the first to examine cash-for-care schemes in practice were Ungerson and Yeandle (2007) who undertake cross-national comparison of their development and consider service users and care workers’ experiences. Mapping the policy context in conjunction with individuals’ experiences reveals the relationship between the micro and macro. Yeandle and Stiell’s (2007) chapter considers the development of Direct Payments in eldercare in the UK using a small-scale exploratory study. They conclude that Direct Payments can be both positive and negative for older people and care workers (Yeandle and Stiell 2007). Older people interviewed highly valued having more choice regarding the care they received, however, choice was dependent on the availability of suitable care workers. Some care workers interviewed enjoyed their role but raised issues regarding their employment rights and job insecurity (Yeandle and Stiell 2007). Whilst the experiences of older people also affect unpaid carers, Yeandle and Stiell (2007) and Ungerson and Yeandle (2007) do not specifically consider the experiences of carers of those in receipt of cash-for-care schemes.

The evidence base regarding carers’ experiences of ‘routed wages’ schemes in the UK is limited (Larkin and Dickinson 2011). Much of the empirical literature focuses on older and disabled people and their use and experiences of cash-for-care schemes rather than carers (Mitchell et al 2014; Moran et al 2012; Larkin and Dickinson 2011; Glendinning et al 2009). Some studies examine the experiences of carers of those who are receiving a Personal Budget or Direct Payment (Moran et al 2012; Waters and Hay 2009; Glendinning et al 2009; Carers UK 2008). Evidence regarding carers’ experiences of cash-for-care schemes in practice indicates there are a number of benefits for carers if the person they care for is in receipt of one of these provisions. Benefits include: an improved financial situation; feeling better supported in their caring role; improved quality of life; feeling like an equal partner in planning support; and reported enhanced family relationships (Moran et al 2012; Glendinning et al 2009; Waters and Hay 2009; Carers UK 2008).

The majority of carers in Waters and Hay’s (2009) small-scale quantitative study in one English local authority, reported a positive impact when the cared-for person received a Personal Budget. Carers did not feel, however, that the personal budget improved their capacity to undertake paid work, or that it improved the choice and control they have over ‘the important things in their life’ (Waters and Hay 2009). On the other hand, carers interviewed in Glendinning et al’s (2009) large scale evaluation of the Individual Budgets (IBs)[[18]](#footnote-18) pilot projects reported greater choice, control and use of time, as well as improved quality of life for the service user and improved family relationships, in comparison with those in receipt of conventional services. Including a comparison group elicited the differences between those receiving IBs and those in receipt of traditional services. Carers of those in receipt of IBs were also more likely to report being fully occupied in activities of their choice and to report having no outstanding needs for social participation and involvement (Moran et al 2012; Glendinning et al 2009).

International studies, however, have found that carers of those receiving routed wages often face additional responsibilities such as recruiting personal assistants, completing paperwork, dealing with payroll, and organising holiday and sickness cover (Grootegoed et al 2010; Rosenthal et al 2007). Rosenthal et al (2007) refer to these tasks as ‘managerial care’ in their large-scale study of working age carers providing care to an older person in Canada. Regression analysis of data from the Work and Family Survey (1992) indicated that these managerial care tasks have a negative impact on carers’ stress and jobs. Similarly, carers in Grootegoed et al’s (2010) qualitative study of relatives’ experiences of payments for care in the Netherlands reported that the introduction of cash payments results in carers placing higher demands on themselves and increased feelings of a duty to perform. Carers did, however, also value the increased recognition and status associated with receiving cash-for-care payments (Grootegoed et al 2010).

Evidence regarding carers’ receipt of both wages and routed wages, such as Direct Payments and Personal Budgets, in practice is now available through the DWP Work and Pensions Longitudinal Study and Community Care Statistics of adult social care activity in England, respectively. Carer’s Allowance (CA) is the main financial support available for carers and is an income replacement benefit for carers who have foregone paid employment to undertake care (Fry et al 2011). The majority (72%) of those claiming CA are women and of peak working age (40-59) (DWP  2016). Women are more likely to have been claiming CA for over 5 years (77% in comparison to 23% men) (DWP 2016). Carers in Fry et al’s (2011) mixed methods study of CA claimants, were mostly white British (79%) and people with no, or very modest levels of, formal educational qualifications. Carers were also mostly female (69%) and aged 35-59 (72%). Evidence suggests that carers of peak working age, women, those who are white British and with lower levels of qualifications are more likely to be claiming CA (Fry et al 2011).

Interviews and discussion groups with carers indicated that carers highly value the symbolic nature of CA and recognition from government of the work they carry out, as well as the financial independence it brings (Fry et al 2011). Most carers in Fry et al’s (2011) study, however, expressed difficulty finding flexible jobs that would accommodate their caring responsibilities and found it difficult to access courses. Similarly, carers in Parker et al’s (2014) study reported they would be unable to consider employment without provision of substantial formal care services. CA is often cited as one of the main reasons for which carers do not increase their working hours, do not return to work, or undertake low-paid, part-time or under-skilled work (Fry et al 2011; Arksey and Glendinning 2008; HoCSC 2008; McLaughlin 1991).

As CA can only be claimed if you are caring for someone with ‘substantial needs’ for over 35 hours a week, if you are not earning more than £116 a week, and if you are not studying for more than 21 hours a week (GDS 2017), Moullin (2007) states it provides little incentive to combine work and care or undertake education or training. Carers in Parker et al’s (2014) and Fry et al’s (2011) studies also did not view CA as separate from the household budget and often did not spend it on themselves (Parker et al 2014, Fry et al 2011). Furthermore, CA has often been associated with an increased risk of poverty and social exclusion, due to its low rate (£62.10 a week or £1.67 an hour) (Berthoud 2010; Arksey et al 2005). Consequently, although CA provides some financial support and recognition for carers who have left the labour market to care, it is often not conducive to work-care reconciliation and can put carers at risk of poverty and social exclusion.

Following the 2004 Carers (Equal Opportunities) Act and Care Act (2014), local authorities are required to assess the needs of those with substantial caring responsibilities in their own right, including in relation to education, training and employment. Following an assessment, carers may receive support or services, including Direct Payments (since 2000). In 2013, statistical analysis of adult social service provision indicated that only 209,470 carers of working age were offered an assessment or review (HSCIC 2014). In 2014, only 225,000 carers of working age (about 10%) were in receipt of services (HSCIC 2015). Furthermore, analysis indicated that for 23% of all requests for support, local authorities provided no direct support; the majority (43%) of carers received only information, advice, or signposting. 20% received a direct payment (HSCIC 2015). The introduction of the Care Act (2014), however, strengthens the right of carers to an assessment and to receive services in their own right, which may increase the amount of carer’s assessments carried out.

In practice, Seddon and Robinson (2015) argue that practitioners are often reluctant to complete separate assessments for carers. Qualitative longitudinal research over a period of 20 years regarding the attitudes of practitioners towards carer’s assessments indicated that in 2001 practitioners were ambivalent to undertaking a separate carer assessment and that in 2012, following policy and legislative developments, practitioners remained ambivalent (Seddon and Robinson 2015). Interviews with practitioners in Mitchell et al’s (2014) study revealed that carer’s assessments are not often coordinated with the assessment or needs of the care recipient and do not capture the complex and dynamic nature of caring relationships (Mitchell et al 2014). As Clements (2011) states, cash-for-care schemes and support services for carers have developed separately to those for disabled and older people, which often results in incongruity between the two. Furthermore, carers in Seddon et al’s (2004) qualitative study of the experiences of carers of older people, stated they had limited opportunity to discuss their wishes regarding employment, training and learning.

Work-care reconciliation has often been conceptualised in policy and existing research as the commodification of care. It is evident there has been a shift towards cash-for-care schemes and the commodification of care in the UK and internationally, driven by a number of factors, including an ageing population. Although carers identified a number of positive outcomes because of the cared-for receiving personal budgets and Direct Payments, evidence regarding carers’ receipt of Direct Payments in their own right is limited, probably due to the low number of carers assessed and awarded Direct Payments in practice. Evidence available suggests, however, that the caring relationship and carers’ wishes regarding employment, training and learning are not often considered during assessments. As Ungerson (1997, 1995) argues, cash-for-care schemes in practice seem to disadvantage some groups (women in particular) more than others and can lead to social exclusion. Existing research indicates that cash-for-care schemes do not provide sufficient remuneration or provide sufficient services to free up carers to work. The concept of ‘commodification of care’ is useful for understanding the development of cash-for-care schemes, and the direction of social care policy in the UK and internationally but is limited in helping us understand the processes which promote carers’ work-care reconciliation in practice.

 ‘Establishing an ethic of care’ is a more useful concept and so is used in the thesis. According to an ethic of care perspective, care and dependence are central to human existence, and care is a practice underpinned by certain moral and political values (Tronto 2013, 1993; Held 2006; Williams 2002; Kittay 1999; Sevenhuijsen 1998). An ethic of care recognises the value of care and carers, without viewing it in market terms which, according to Held (2006), is one of the least effective ways of valuing care.  Support and services from an ethic of care perspective also consider the caring relationship and capture its’ dynamic and complex nature (Lloyd 2010). Furthermore, as a feminist perspective, an ethic of care strives to ensure that support and services are inclusive of all and do not disadvantage certain groups in society (Lloyd 2010). An ethic of care as a concept can incorporate all spheres of society, the state, market, family and civil society, and does not imply a specific relationship between one or more of the sectors. An ethic of care is used in the thesis to help understand how voluntary organisations can promote carers’ work-care reconciliation.

## 2.6 Summary

The chapter critically examines the theories and concepts used in existing research and policy documents, to examine work-care reconciliation. It demonstrates that work-care reconciliation has been theorised in four principal ways: in terms of work-life balance; role theory and role stress theory; boundary theory; and in relation to the commodification of care. The chapter illustrates, however, that these theories and concepts: focus on the individual rather than social relationships; are cross sectional rather than longitudinal; and do not seek to challenge inequalities in relation to paid work and unpaid care. Furthermore, these theories conceptualise work-care reconciliation as a relationship between the market and family (role theory), market, family and the state (boundary theory) and market and family, with a reduced role for the state (commodification of care). They do not consider the role of civil society. The chapter demonstrates that ‘work-care reconciliation’, ‘creating a carer-friendly workplace’, ‘delivering person-centred support’, and ‘establishing an ethic of care’, are more useful for understanding the processes which promote carers’ work-care reconciliation in practice. These concepts focus on relationships, are longitudinal, incorporate a commitment to equality, and can include the sphere of civil society.

Empirically, a substantial body of research regarding work-care reconciliation in the UK has now developed. The chapter indicated that previous research considers the work-care reconciliation challenges carers face and the impact of work-care reconciliation for carers, businesses and the wider economy. Existing research also examines how carers manage work and care, their work-care reconciliation support needs, and the development of cash-for-care schemes. Analysis, however, focuses on the individual, organisational and policy level, rather than considering the relationships important for understanding how carers’ work-care reconciliation can be promoted. Methodologically, researchers employ a range of strategies to examine the relationship between work and care, however, a mixed methods approach provides a holistic view of work-care reconciliation in practice, although it is important to emphasise the voice of carers. Longitudinal research is also important when examining work-care reconciliation as the relationship between the two shifts and changes. A longitudinal mixed methods approach, through a case study, will be used for the empirical research in the thesis, and analysis will focus on social relationships.

# Chapter 3: Understanding the role of voluntary organisations in promoting carers’ work-care reconciliation

## 3.1 Introduction

Chapter 2 demonstrated that theories and concepts used to examine work-care reconciliation often conceptualise it as a relationship between factors within the state, the market, and the family. Chapter 1 noted the increasing role that voluntary organisations play in society and in delivering publicly-funded services. This chapter discusses how voluntary organisations and civil society have been conceptualised in previous research and policy documents, with particular reference to their role in promoting the work-care reconciliation of carers. It identifies the concepts important for understanding the role of voluntary organisations, outlines the conceptual framework used in the thesis, and notes the importance of ‘an ethic of care’ in understanding how voluntary organisations approach supporting carers to combine work and care. It also considers the role of ‘civil society’ in delivering services within this ethical framework and highlights gaps in the literature which the thesis aims to fill. The focus is predominantly on research undertaken on voluntary organisations in England[[19]](#footnote-19), although where relevant some other European research is also referred to.

The chapter addresses five main issues: competing conceptualisations of the sphere between the market and state, and why the concept ‘civil society’ is used in the thesis (Section 3.2); how voluntary organisations implement services to promote carers’ work-care reconciliation, the extent to which these are implemented in line with an ethic of care, and their impact for carers (Section 3.3); the role of partnerships, and of civil society in supporting partnerships (Section 3.4); how voluntary organisations promote ‘social inclusion’ to support carers’ work-care reconciliation (Section 3.5); and the challenges to sustainability which voluntary organisations face and the implications of these for voluntary organisations promoting carers’ work-care reconciliation (Section 3.6). Section 3.7 summarises the main arguments of the chapter.

## 3.2 Conceptualisations of civil society

Defining the sphere between the market and the state has been the subject of much debate (Alcock 2010); some authors question whether there is a definitive ‘sector’ (Grotz 2009; Osborne 2008; Laville et al 1999), and Kendall and Knapp (1995) refer to it as a ‘loose and baggy monster’. Until the end of the 20th century, the term ‘voluntary sector’, meaning voluntary organisations engaged in voluntary action (Hilton and McKay 2011), was widely used in policy documents and by researchers. The Wolfenden Report[[20]](#footnote-20) established the voluntary ‘sector’ as an area of policy interest (Wolfenden Committee 1978) and during the 1980s voluntary organisations became alternative providers within a plural market and welfare state (McLaughlin et al 2002). The term ‘voluntary sector’ is limited, however, as it only refers to the collective of organisations that undertake ‘voluntary action’ (Hilton and McKay 2011). In his work on the welfare state in the 1940s, Beveridge (1948) had referred to voluntary action as actions undertaken independently from the state and for a social (rather than commercial) purpose, while Knight (1993) subsequently defined the ‘voluntary sector’ as the collective of organisations which are operationally and financially independent, are not-for-profit, and use volunteers. As Benard et al (2017) point out, however, the term ‘voluntary sector’ refers to a set of specific organisations, with a defined function, and does not capture the breadth of organisations which now operate in this sphere (see also Chapter 1).

During the New Labour era (1997-2010) the term ‘third sector’ became popular (Alcock 2010); the first Compact agreement[[21]](#footnote-21) outlined a closer partnership between the sector and government (Home Office 1998) and in 2006 the New Labour government established an Office of the Third Sector. The term was indicative of New Labour’s policy rhetoric regarding the ‘third way’, which sought to reconcile right- and left-wing politics (Giddens 1998). Seeing voluntary organisations as playing a key role in delivering public services, Gordon Brown, then Chancellor, stated: “[we want to see] a transformation of the third sector to rival the market and the state, with a quiet revolution in how voluntary action and charitable work serves the community” (Brown 2004). In academia, a Third Sector Research Centre (TSRC) was established in 2008, which aimed to develop the research and evidence base on the sector (TSRC 2010). The ‘third sector’ concept refers to a range of organisations which is wider than the ‘voluntary sector’, as it includes both voluntary and community organisations, and social enterprises, charities, mutuals, and cooperatives (HoCPaSC 2008). The term, which still defines the sector in terms of the organisations within it, also implies that there are (only) three sectors in society, the state, the market and the third sector, although as Alcock and May (2014) note, families provide the majority of social care.

In the General Election campaign in 2010, the Conservative Party promoted the concept of a ‘Big Society’ (Conservative Party 2010). Its Manifesto (2010) held that a ‘Big Society’ would shift power away from government towards local government and local communities. At the helm of the subsequent Coalition government (2010-2015), the Conservatives continued to advocate the Big Society (Cabinet Office 2010b), and a ‘Building the Big Society’ strategy document outlined its intention to support the expansion of voluntary organisations by supporting them to play a greater role in delivering public services (Cabinet Office 2010a). The ‘Big Society’ concept was criticised, however, as a ‘cover’ for the cuts to public expenditure which the then Prime Minister, David Cameron, proposed (Coote 2010). A *Guardian* article later argued that the term ‘Big Society’ quickly fell out of favour, noting that David Cameron had not used the term since 2013 (Butler 2015). The Office of the Third Sector was re-named the Office for Civil Society in 2010 (Mair 2010) at around the same time as the NCVO (National Council of Voluntary Organisations) re-named its annual statistical review of the voluntary sector the Civil Society Almanac (Alcock 2010). The current Conservative Government (in office since 2015) tends to use the term ‘civil society’.

The term ‘civil society’ has also been widely debated. Some define it in terms of its forms; that is, as those organisations which are independent of the state and of the market (Keane 1998); others view it as the space in which social norms, such as trust and reciprocity, are generated (Putnam 2000, 1995, 1993; Fukuyama 2001). It is sometimes seen as the part of the public sphere where people come together in associational life and debate public issues (Edwards 2011; Gramsci 1971; Habermas 1962). There is also debate about whether the family is, or should be, seen as part of civil society (Cohen and Arato 1994). Following Edwards (2011), civil society is defined in this thesis, in terms of forms, norms and space, and as the space between the market, the state and the family, since incorporating all three of these provides the most comprehensive definition. While a wide range of organisations operate within civil society, voluntary organisations are at its core (Keane 1998). Civil society as conceptualised in this thesis is characterised by (although it does not produce) norms of trust and reciprocity (Edwards, 2011)[[22]](#footnote-22) which form part of the normative infrastructure of voluntary organisations (Anheier and Kendall 2000). The family, however, is viewed (in this thesis) as separate from civil society, because the organisational forms of the family, such as households, are significantly different from voluntary organisations, which are central to civil society (Anheier 2005).

‘Civil society’ is used in the thesis as a useful theoretical concept for examining the role that voluntary organisations can play in promoting carers’ work-care reconciliation. As a concept, it has several advantages over possible alternative concepts; it is theoretical (see Chapter 1) and encapsulates not only the organisations within it, but also the space and norms that characterise it (Edwards 2011). Terms such as ‘voluntary sector’ and ‘third sector’, by contrast, refer only to the organisations, and not to the norms or spaces, of the sphere between the market and state. Conceptualising this as a ‘space’ (rather than a ‘sector’) also avoids contention as to whether there is a perceptible ‘sector’. ‘Civil society’ recognises the multitude of organisations within this sphere, although voluntary organisations remain at its core. The concept goes further than ‘voluntary sector’ and ‘third sector’ (both primarily descriptive terms) and is useful in understanding both the organisations which support carers to combine work and care, and how (and why) voluntary organisations are able to promote carers’ work-care reconciliation.

## 3.3 Policy implementation

‘Policy implementation’ refers to what happens between policy design and policy outcomes (Cairney 2012; O’Toole 2000; Ferman 1990), and as such is important for understanding the role of voluntary organisations in promoting carers’ work-care reconciliation. It concerns how actors deliver policies, and the impact of this for service users (Cairney 2012; Parsons 1995). Competing theories of policy implementation emphasise different factors: ‘top-down’ theorists argue that successful implementation requires both a clear, well-communicated policy and competent and compliant staff (Pressman and Wildavsky 1979; Van Meter and Van Horn 1975); whereas ‘bottom-up’ theorists highlight the role of ‘street level bureaucrats’, or frontline workers, claiming they have a significant impact on implementation and are, in reality, the ones who make policy (Matland 1995; Hjern 1982; Barrett and Fudge 1981; Lipsky 1980). Sabatier (1986) attempts to synthesise the two perspectives, using the concept of ‘policy networks’, a term which refers to the set of actors involved in dealing with a policy problem. Actors include government, academics, frontline workers and organisations (Weible et al 2009; Sabatier 1998, 1986).

However, evidence from past research has suggested that when voluntary organisations promote carers’ work-care reconciliation, the ‘ethic of care’ is an important factor (Wigfield and Marangozov 2014; Vickerstaff et al 2009; Arksey 2003). Feminist political theorists have conceptualised an ethic of care in ways which can be related to the policy cycle, and as comprising ‘attentiveness’, ‘responsibility’, ‘competence’ and ‘responsiveness’. Tronto (1993) links these to the four stages of caring - caring about, caring for, care-giving and care-receiving, as set out by Tronto and Fisher (1990). Attentiveness relates to caring about, responsibility to caring for, competence to care-giving and responsiveness to care-receiving (Tronto 1993). These concepts can relate to the policy cycle[[23]](#footnote-23), with attentiveness relating to setting the policy agenda, responsibility to policy design, competence to policy implementation and responsiveness to policy outcomes. Some research suggests that voluntary organisations recognise that carers need support (attentiveness) and take responsibility to provide that support (responsibility) (Wigfield and Marangozov 2014; Vickerstaff et al 2009), despite the policy position which is that Jobcentre Plus is the official provider of employment support for carers (HM Government 2010, 2008).

In Wigfield and Marangozov’s (2014) study of effective employment support for carers, all six examples were voluntary organisations, and carers in Vickerstaff et al’s (2009) study of the employment support needs of carers reported that they highly valued support offered by voluntary organisations. Within the ACE National partnership (explored further in the following section), most organisations delivering employment support for carers were voluntary organisations. There has been debate about responsibility and obligation in relation to an ethic of care. Some authors argue that people have a duty to care and are morally obliged to look after those who are more vulnerable in society (Engster 2007, 2005; Kittay 1999; Noddings 1984), but those writing about ethic of care tend not to advocate an obligation to care. Thus Sevenhuijsen (2002, p.134) states:

“The ethic of care does not presume that the caring actor has a universal moral obligation to care for the needs of others, an obligation that some writers derive from a ‘feminine impulse to care on behalf of the other”.

Obligation implies a sense of duty to undertake care, whereas responsibility implies a willingness and desire to do so (Tronto 1993). Civil society provides the space in which voluntary organisations can form to tackle societal issues, such as work-care reconciliation (Edwards 2011; Gramsci 1971; Habermas 1962), and (according to Weisbrod’s (1988) theory of state failure and Hansmann’s (1987, 1980) theory of market failure), voluntary organisations tend to emerge to fill gaps in statutory or market services.

Evidence from existing research also indicates that voluntary organisations often provide work-care reconciliation support which is appropriate for carers and delivered by proficient staff (in line with ‘competence’ of an ethic of care) (Wigfield and Marangozov 2014; Vickerstaff et al 2009; Arksey 2003). In-depth case studies in Wigfield and Marangozov’s (2014) study indicated that voluntary organisations were effective at providing employment support for carers because they provided flexible, tailored support, had local labour market knowledge, and employed staff with specialist knowledge (Wigfield and Marangozov 2014). Carers interviewed in Vickerstaff et al’s (2009) study often trusted the advice, information, and support, offered through voluntary organisations more than other organisations. This was due to their perceived reliability and accessibility, as well as their embeddedness in the local community (Vickerstaff et al 2009). Carers who accessed the People into Employment project (a local project delivered by a voluntary organisation which aimed to support carers, former carers and disabled people into work) highly valued the flexible and tailored on-going support it offered (Arksey 2003). According to Arksey (2003), the success of the project was partly due to dedicated, committed staff. These studies, however, do not undertake longitudinal research into implementation of services in practice, which is addressed in the present thesis.

Evidence from existing research regarding the role of voluntary organisations in promoting carers’ work-care reconciliation indicates that staff are often ‘competent’. While this suggests it is voluntary organisation staff, or street level bureaucrats, who play the key role in policy implementation, competence in line with an ethic of care helps us further understand the role voluntary organisations play in promoting carers’ work-care reconciliation. Indeed, evidence from an evaluation of the NEC (National Extension College) Carers into Education project indicates that voluntary organisations can be effective at providing training for carers as, compared to statutory courses, courses are more flexible and are timed to fit carers’ needs (NIACE and NEC 2009). Similarly, a comparative report coordinated by Eurocarers (2016) into the learning opportunities of carers across Europe emphasises the role of voluntary organisations in providing training and concludes that voluntary organisations often provide free training for carers that is flexible to their needs (Eurocarers 2016). Competence in relation to an ethic of care refers not only to the role of staff delivering services, but also to the appropriateness of the services delivered.

Existing research also suggests that trust is important for voluntary organisations to implement work-care reconciliation support in practice (Eurocarers 2016; Wigfield and Marangozov 2014; NIACE and NEC 2009; Vickerstaff et al 2009; Arksey 2003). Sevenhuijsen (1998) adds the concept of trust to Tronto’s four moral concepts of an ethic of care and argues that the care-receiver must be able to trust the carer for care to be of decent quality. She argues that trust in relation to ethic of care is a verb, a dynamic social action, rather than a characteristic of caring relations (Sevenhuijsen 1998; Baier 1985). Carers often accessed voluntary organisation support and training as they had confidence in the ability of these organisations to provide appropriate, quality services (NIACE and NEC 2009; Vickerstaff et al 2009). As outlined previously, civil society is characterised by social norms such as trust (Edwards 2011) and some authors argue that voluntary organisations are ‘distinct’ from other organisations, as they are more likely to be trusted (Arvidson and Kara 2013; Anheier and Kendall 2002; Tonkiss and Passey 1999; Billis and Glennerster 1998; Hansmann 1980). Early theorists (Weisbrod 1988; Hansmann 1980) argued that people are more likely to trust voluntary organisations as they do not seek to generate profit and are more likely to act in accordance with the needs of beneficiaries. Similarly, and more recently, Anheier and Kendall (2000) have argued that voluntary organisations are often trusted due to the absence of market logics.

Evidence from previous research indicates that policy implementation, defined in relation to an ethic of care (attentiveness, responsibility, competence), is important for understanding the role of voluntary organisations in promoting carers’ work-care reconciliation. Trust, which is also central to an ethic of care, is important for voluntary organisations to implement work-care reconciliation support in practice. Some voluntary organisations have recognised that carers often need support to combine work and care and have taken responsibility to provide this. Evidence also indicates that voluntary organisation staff tend to be competent and provide appropriate services. Civil society can provide the space in which voluntary organisations can form to provide such support and is characterised by trust, which is important for policy implementation in practice.

## 3.4 Partnership working

Voluntary organisations promoting carers’ work-care reconciliation have tended to emphasise, and to engage in, ‘partnership working’. While there is no single definition of partnership working, authors often define it as the relationship between two or more actors working together to achieve a common aim, characterised by a degree of trust and reciprocity (Cropper et al 2009; Glasby and Dickinson 2008; Glendinning et al 2002; Sullivan and Skelcher 2002). Partnerships can range from strategic alliances and informal collaborations to mergers and full integration (Rees et al 2012a; Harris et al 2002). Advocates of partnership working often argue that it results in more effective and efficient services (Huxham and Vangen 2009, 2005), claiming that its benefits include access to additional resources; information sharing; greater continuity in service provision; and innovative responses to complex issues (Petch et al 2013; Audit Commission 1998). Some writers see partnership working as an effective way of delivering services in a plural welfare state and of tackling complex issues in society, such as an ageing population (Nies 2009; Balloch and Taylor 2001).

In the UK, governments have emphasised the importance of working in partnership to support carers. The National Carers’ Strategy 2008 stated that, “any realistic solution to the challenge of improving carers’ lives must recognise that the individual, family and state must work in partnership” (HM Government 2008, p11), citing, as an example of best practice in supporting carers to combine work and care, the partnership between Jobcentre Plus and voluntary organisations which helped raise awareness in Jobcentre Plus of issues which carers face (HM Government 2008). An updated version of the strategy (HM Government 2010), under the Coalition Government, stated that the DWP (Department for Work and Pensions) should investigate the potential of working in partnership with voluntary organisations to provide employment support for carers. Partnership working was also found to be important for delivering effective employment support for carers in Wigfield and Marangozov’s (2014) and Arksey’s (2003) studies.

Partnership working within the context of an ethic of care has been shown in previous research to be important for understanding the role of voluntary organisations in promoting carers’ work-care reconciliation. The concepts of ‘mutualism’ and ‘autonomy’ of an ethic of care are relevant for partnership working: mutualism signifies that people are interdependent, or necessarily dependent, upon one another (Williams 2002); autonomy recognises that human capacity develops through relationships (Young, 1997), and recognises that, like ‘agency’, individual capacity is relational, and is sensitive to the environment in which social action takes place (Giddens, 1984). One example of voluntary organisation partnership working characterised by mutualism is the ACE National Partnership (2002-2007) which aimed to identify barriers which carers face to employment and develop mechanisms to support carers to combine work and care or return to work (Yeandle and Starr 2007). Delivered in two phases, (2002-2005 and 2005-7), and led by the national voluntary organisation Carers UK, it aimed to address some of the barriers carers face in accessing employment and sought to influence policy regarding alternative care services that can enable carers to combine work and care (Yeandle and Starr 2007).

The evaluation of ACE (Formby and Yeandle 2005) highlighted the importance of partnership working, exemplified in the ACE ‘delivery partnership’; ‘policy partnerships’; ‘research partnership’; in its development of the ‘Employers for Carers’ group; and in its ‘transnational partnership’, all part of this voluntary organisation’s activity in promoting carers’ work-care reconciliation (Yeandle and Starr 2007). These partnerships were developed with actors at various levels to implement the ACE programme and can be understood as exemplifying mutualism of an ethic of care, as actors within the ACE programme recognised how the agency of carers can be developed through human relationships and used partnership working to promote carers’ work-care reconciliation at the local, national, and international levels (Yeandle and Starr 2007). ACE piloted local employment support projects for carers; influenced the planning and delivery of support from local agencies; achieved significant impact on the national policy agenda (including by influencing legislation and working closely with government and businesses. Internationally, it was instrumental in setting up Eurocarers (the lobbying and campaigning group), ensured the EU Social Agenda addressed carers’ concerns, and enabled the international exchange of best practice in employment support for carers (Formby and Yeandle 2005).

Yeandle and Starr (2007, p.28) concluded that “the ACE partnership showed how much can be achieved through energetic, focused and committed collaborative working”. Mutualism, and autonomy of an ethic of care were evident in how ACE promoted carers’ work-care reconciliation, through partnership working and relationships with stakeholders, with partnership working and human relationships seen as essential for increasing the agency of carers. The ACE partnership also exemplified the importance of reciprocity in actions to promote carers’ work-care reconciliation. In Tronto and Fisher’s (1990) stages of caring, reciprocity relates to responsiveness. Some authors argue against including reciprocity in an ethic of care, objecting to its contractarian implication of equivalent exchange (Barnes 2012; Held 2006; Tronto 1993), and claiming that reciprocity implies obligation. These authors, however, refer to reciprocity as a noun rather than a verb. Reciprocity as a verb is a relational concept and social process. As a relational concept, reciprocity refers to the contribution of the care recipient to the caring relationship, in line with responsiveness.

According to Yeandle and Starr (2007), the ACE project would only succeed if Carers UK ensured the commitment and active participation of the partner agencies. Indeed, without the ongoing engagement of local organisations, policy makers, employers and international actors, the ACE partnership would not have been able to pursue its aims (Yeandle and Starr 2007; Formby and Yeandle 2005). Mutual partnerships, characterised by reciprocity, were important for the ACE partnership to promote carers’ work-care reconciliation. Some authors argue that civil society provides the space where people can come together in associational life (Fukuyama 2011; Edwards 2011, 2004; Foley and Edwards 1996), with Edwards (2011) claiming civil society is also characterised by social norms such as reciprocity. Past studies have shown that the forms, norms and space of civil society are conducive to partnership working in line with mutualism, and that civil society provides a space in which people can come together in associational life, with voluntary organisations working in partnership to support work-care reconciliation. As demonstrated in later chapters of this thesis, the norms of civil society, such as reciprocity, are essential for partnership working in practice.

## 3.5 Social inclusion

‘Social inclusion’ is another concept which is important for understanding the role of voluntary organisations in promoting carers’ work-care reconciliation. Again, there is no agreed definition (DESA 2010), although some writers define it in terms of ‘participation’ and the extent to which someone has access to the labour market and social networks, to political representation, to access to services, has ‘a voice’ and has the ability to participate in cultural events (Mathieson et al 2008; Pantazis et al 2006; Atkinson et al 2002; Silver 1994). In much social policy and social norms, however, participation is equated with labour market participation (Patrick 2012; Lister 2001). Many feminist authors argue that activities such as providing unpaid care are also a form of participation (Sevenhuijsen 1998; Knijn and Kremer 1997; Young 1997). In some cases, social inclusion is defined as the opposite of social exclusion (Hickey & du Toit, 2007; Charity Commission 2001), while others argue against this, defining it in relation to social quality (Walker and Wigfield 2004). Others see social inclusion as a multidimensional, dynamic social process (DESA 2010; Levitas 2005; Gordon et al 2000; Sen 2000; Lister 1998).

Carers, especially those who have left the labour market to care, can be at risk of social exclusion (Howard 2001; Holzhausen and Pearlman 2000), with women and people from BAME communities (who are more likely to provide care) often at increased risk of social exclusion (Becker 2000). Past research suggests that social inclusion, understood as inclusive diversity and voice (consistent with an ethic of care) is important for understanding voluntary organisations’ approach to promoting carers’ work-care reconciliation. ‘Inclusive diversity’ takes difference into account, acknowledges the heterogeneity of carers and caring relationships, and recognises that aspects of social identity such as gender and ethnicity affect the experience of giving and receiving care (Williams 2002). ‘Voice’ refers to the extent carers can express their views (Williams 2002), for example on work-care reconciliation policy and support services, and the extent to which policy-makers and service providers take these into account. As Whitaker (1980) points out, voice is not mere consultation, but involves having one’s views listened to and acted upon.

Voluntary organisations have been shown to be effective at engaging with carers. Evaluation studies of two England-wide programmes, the Caring with Confidence (CwC) programme[[24]](#footnote-24) and the National Carers’ Strategy Demonstrator sites programme[[25]](#footnote-25), found that voluntary and carers’ organisations found it easier to recruit carers, that most carers who accessed these programmes had heard about them through a voluntary organisation or carers’ centre, and reported that trust was vital, with carers trusting voluntary organisations more than statutory agencies [partly because voluntary organisations could develop relationships of trust with carers through face-to-face contact (Yeandle and Wigfield 2011a, 2011b)]. Edwards (2011) notes that civil society is characterised by trust, and Anheier and Kendall (2002) have argued that voluntary organisations are particularly effective at engaging with people at risk of social exclusion as they are well trusted and often embedded in local communities. Billis and Glennerster’s (1998) theory of comparative advantage is also relevant here: with their specialist knowledge and experience, voluntary organisations ore often well placed to deliver services to those at risk of social exclusion, who are more likely to trust organisations which are independent of both the state and the market (Billis and Glennerster 1998). Policymakers also seem to share this view:

“Voluntary and community organisations (VCOs), including social enterprises…grow out of the determination to provide high quality support to particular groups and are often uniquely placed to reach marginalised groups and enable individuals to participate actively in their local communities”

 (HM Treasury 2002, p.5).

If civil society is characterised by the norm of trust, has voluntary organisations at its centre and provides a space which is independent from the state and the market, it is likely to be conducive to promoting carers’ social inclusion. Much research seems to confirm this: evidence from Work Integration Social Enterprises[[26]](#footnote-26) in the UK has shown voluntary organisations to be effective at engaging with those who are disadvantaged and skilled at developing relationships of trust (Borzaga et al 2008; Spear 2002), and a study of the experience of civil society subcontractors in a European Social Fund programme in 2007-13 (which aimed to support ‘people get better jobs’) found voluntary organisations were especially effective at engaging with people in areas of high unemployment, people who lacked basic skills and qualifications, and women, with most survey respondents in Crisp et al’s (2010) mixed methods study saying ESF funding had enabled them to deliver a high-quality service and to engage with disadvantaged individuals.

‘Giving carers’ voice’, crucial from an ethic of care perspective, is also important for understanding the role of voluntary organisations in promoting carers’ work-care reconciliation. Cook argues that by persistently lobbying and campaigning on behalf of carers, carers’ organisations have been highly successful in instigating policy change (Cook 2007). He highlights their role in introducing legislation relevant to carers, including the Carers (Recognition and Services Act (1995), the Carers (Equal Opportunities) Act (2004) and the National Carers’ Strategies (2010, 2008, 1999). Similarly, the ACE partnership effectively raised awareness of the needs of carers regarding employment and instigated policy changes (Yeandle and Starr 2007). Case study interviewees who delivered the CwC programme reported that delivering CwC had increased awareness of carer issues and led to a greater understanding of carers’ roles, both within their own organisations, and within the wider community (Yeandle and Wigfield 2011b). Staff delivering Demonstrator Sites services also reported increased carer awareness amongst colleagues (Yeandle and Wigfield 2011a). According to Yeandle and Wigfield (2011a), carers were also involved in the design and implementation of services. All sites involved carers in designing services and several (16 out of 25) sites developed forums to discuss policy and service implementation (Yeandle and Wigfield 2011a).

In this thesis, it will also be argued that civil society provides the space in which voluntary organisations can give carers voice. Edwards (2011) has emphasised the independence of civil society from the state and the market, and Billis and Glennerster (1998) have shown voluntary organisations to be effective at engaging with those at risk of social exclusion. Trust, as a norm of civil society, is important in enabling organisations to engage with those at risk of social exclusion, and social inclusion, in terms of inclusive diversity and giving voice of an ethic of care, is important for understanding the role of voluntary organisations in promoting carers’ work-care reconciliation.

## 3.6 Sustainability

There is no one definition of ‘sustainability’ and initially authors defined it in relation to the environment (McKenzie 2004). More recently, economic and social sustainability have received increasing attention from academics and policymakers (Dillard et al 2009) and these concepts are important for the thesis (Dillard et al 2009). Drawing on organisational and management literature, economic sustainability refers to the ‘future proofing of organisations’ (Colbert and Kurucz 2007). It relates to the ability of organisations to secure the required resources to maintain operational functioning but also to seize new opportunities and tackle unexpected challenges (Bowman 2011; Doane and MacGillivray 2001). ‘Social sustainability’ has received less attention in literature although some authors have developed a working definition which is drawn on in the thesis (Dillard et al 2009; Magis and Shinn 2009; McKenzie, 2004).

According to these authors, social sustainability concerns the well-being of citizens and four universal principles: human well-being; equality; democratic governance; and democratic civil society (Dillard et al, 2009; Magis and Shinn, 2009; McKenzie, 2004). Social sustainability in this thesis, however, refers to the ability of voluntary organisations to deliver services in line with the moral and political principles of an ethic of care. As the previous sections argue, these principles are important for understanding the role voluntary organisations can play in promoting carers’ work-care reconciliation. Sustainability does not refer to ‘resilience’, which implies that responsibility for sustainability lies solely with organisations themselves (Milbourne 2013). Sustainability is also a dynamic process and specific actions are required at different points over the life-course of an organisation (Foster 2008). Sustainability in this thesis refers to the capacity of voluntary organisations to ensure financial security and promote the principles of an ethic of care.

Past research has shown that voluntary organisations providing services to promote carers’ work-care reconciliation face a number of challenges to sustainability, and to delivering services in line with an ethic of care. They include securing funding, delivering publicly-funded services, recruiting and retaining staff, partnership working and demonstrating impact (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011a, 2011b; Yeandle and Starr 2007; Formby and Yeandle 2005). This section examines what is currently known about these challenges and considers their implications for the ability of voluntary organisations to promote carers’ work-care reconciliation.

Securing funding is a frequently-mentioned challenge for organisations providing work-care reconciliation support (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011a, 2011b; Formby and Yeandle 2005). Several organisations in Wigfield and Marangozov’s (2014) study had ceased to deliver employment support by the end of their study, as funding streams had ended, and cuts in public funding had reduced their ability to secure further funding. Others had diversified their funding sources or used short-term funds (Wigfield and Marangozov 2014). Yeandle and Wigfield (2011b) found that only eight of the 25 Demonstrator Sites continued to provide services after their DH funding ended, although nine sites also offered partial services. The Department of Health (DH) rescinded funding for the CwC programme prematurely (Yeandle and Wigfield 2011b). Consequently, several providers interviewed reported they had to cease delivering services, putting the organisation or its local reputation at risk (Yeandle and Wigfield 2011b).

Securing funding is an increasing issue for all voluntary organisations in the UK, especially with the shift from grant funding to contracts (Macmillan 2010). Voluntary organisations often find it difficult to compete for public service contracts (Macmillan 2010; Buckingham 2009; Martikke 2008; Shared Intelligence 2008), and past research has shown that without funding and financial sustainability, organisations often cease to deliver services for carers, or restrict or alter service delivery, for example by securing local authority funding, combining their programme with other services, adapting existing services to meet carers’ needs, or developing alternative services, such as an online forum for carers (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011b). Some voluntary sector providers have found funders’ requirements and service delivery models challenging or have found it difficult to operate in an increasingly competitive, marketised environment. Others delivered services within the tariff model, a form of payment-by-results. This caused problems, however, for CwC providers (Yeandle and Wigfield 2011b). Within a PbR system, service providers are paid according to the outcomes they achieve, not in relation to the services they deliver, and consequently, risk transfers to the provider to stimulate performance (Sheil and Breidenbach-Roe 2014). Public service contracts are often on a payment-by-results basis (Suleiman 2014).

To address issues with low numbers of carers accessing services, DH procured additional providers based on a PAYG model of funding, a form of payment-by-results. Although PAYG appeared to reduce costs per carer place, staff interviewed reported this model of funding sometimes resulted in inconsistencies between providers and increased competition (Yeandle and Wigfield 2011b). Existing research from the wider voluntary sector identifies several challenges for voluntary organisations delivering payment-by-results contracts, including ‘creaming and parking’ and issues with referral flows (Heins and Bennett 2016; Damm 2014; Lane et al 2013; Rees et al 2013a; Rees et al 2013b; Work and Pensions Select Committee (WSPC) 2013; Macmillan 2010). ‘Creaming’ refers to prioritising clients who are easiest to help and more likely to achieve a positive outcome (Rees et al 2013b). ‘Parking’ refers to de-prioritising those who are hardest-to-help and least likely to achieve a payment outcome (Rees et al 2013b). According to Rees et al (2013a), voluntary organisations are more likely to experience creaming and parking than subcontractors in other sectors. They state that as voluntary organisations are often conceptualised by prime providers as supporting those who are disadvantaged, those furthest from the labour market are often referred to voluntary organisations (Rees et al 2013).

Researchers have also found that voluntary organisations providing publicly-funded services to support carers can encounter difficulty in delivering these contracts, for example because targets are demanding or unrealistic, or because programme content is fixed and inflexible (Miller and Larkin 2013; Dayson 2011; Yeandle and Wigfield 2011b; Dickinson and Glasby 2010; Harlock 2010). Some organisations providing Caring with Confidence (CwC) services found the contract demanding and difficult to deliver (Yeandle and Wigfield 2011b). The programme aimed to fully train 27,000 carers face-to-face, provide 108,000 carer places and train 10,000 carers online or through self-study. However, by the end of the programme, only 5,427 carers were fully trained, 40,292 places were provided and 1,318 accessed online or self-study. Nearly all organisations had cancelled several modules due to low carer take-up rates. DH ended funding for the programme prematurely, primarily due to low numbers of carers accessing services (Yeandle and Wigfield 2011b). According to Yeandle and Wigfield (2011b), the lower than expected take-up rates were due to over-ambitious targets, rather than a reflection of the ability of organisations to engage with carers. Some staff interviewed felt that course materials were not flexible to the needs of carers and that the National Team were unwilling to allow providers to adapt the programme to reflect local circumstances (Yeandle and Wigfield 2011b).

Some organisations delivering the CwC programme faced difficulty delivering a demanding contract. Target numbers of carers were high and some staff felt that the services commissioned were not appropriate for carers (Yeandle and Wigfield 2011b). Delivering publicly-funded services affects their ability to deliver services in line with an ethic of care. Contracts imply obligation, rather than attentiveness, and may not recognise responsibility for an ethic of care. Evidence from evaluation of the CwC programme indicates that publicly-funded services are not always wholly appropriate for carers, central to ‘competence’ of an ethic of care.Those delivering social care services have reported challenges which include financial insecurity, high or unexpected administration and staff costs, problems with marketing and generating referrals, difficulty in developing partnerships with local statutory organisations and clashes of organisational culture (Dayson 2011; Dickinson and Glasby 2010; Harlock 2010). Harlock (2010) argues that delivering personalised, publicly-funded, services requires a shift in organisational culture for some voluntary organisations to deliver services within a highly marketised and competitive environment.

Some authors identify ‘mission drift’ – described by Arvidson (2009) as a shift away from an organisation’s core values, principles and services - as a particular issue (Rees and Mullins 2016; Shared Intelligence 2009; Charity Commission 2007; Alcock et al 2004). Macmillan (2010). Pfeffer and Salancik (2003), adopting a resource dependence perspective, observe that organisations will adapt according to their environment to secure resources, while DiMaggio and Powell (1983) focus on ‘institutional isomorphism’ – what happens when organisations adopt the characteristics of those that are dominant and more powerful - arguing that the risk of institutional isomorphism is greater if one organisation is dependent upon another for resources. Billis (2010) has developed a theory of hybridisation, in which the boundaries between sectors are increasingly blurred, creating ‘hybrid’ organisations which span or mix the different ‘ideal types’ of public, private and third sector organisations. As voluntary organisations (central to civil society) increasingly deliver public services and operate in a competitive environment, their organisational culture and structure is changing.

Recruiting and retaining staff is a further challenge to sustainability identified in previous research on the role of voluntary organisations in promoting carers’ work-care reconciliation (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011b). Authors have noted that short-term funding can make it difficult to retain key staff members (Wigfield and Marangozov 2014) or to recruit staff in the first place (Yeandle and Wigfield 2011b). Similar findings are reported elsewhere in the voluntary sector, where recruiting and retaining staff has been an issue as use of short-term contracts has proliferated (AGCC 2014; Cunningham and Nickson 2010; Buckingham 2009; Nickson et al 2008; Cunningham and James 2007; Wilding et al 2004). This has been described in one report on recruitment, selection and retention in voluntary organisations, as a ‘revolving door’ (Agenda Consulting 2016).

Evidence from studies in Scotland has particularly highlighted high turnover rates in the voluntary sector compared with the private and public sectors and found that those who left jobs in the voluntary sector tended to take up positions in the public or private sector, where greater security and remuneration was available (AGCC 2014). Cunningham and James (2007) examined the implications of an insecure funding environment for voluntary organisations delivering social care, finding that most had made redundancies in recent years due to precarious funding, and noting high levels of employee anxiety about job security. Competent staff are essential for providing services in line with an ethic of care (Tronto 1993). Changes within civil society and an increasingly insecure funding environment have contributed to higher staff turnover and issues with staff retention which could jeopardise the ability of voluntary organisations to promote carers’ work-care reconciliation.

Monitoring and demonstrating impact, often essential for securing future funding has also been identified as an issue affecting voluntary organisations which promote carers’ work-care reconciliation (Wigfield and Marangozov 2014; Miller and Larkin 2013; Yeandle and Wigfield 2011a, 2011b). Wigfield and Marangozov (2014) found that short-term funding made it difficult to monitor the longer-term outcomes of carer employment support, while some staff involved in delivering the CwC programme reported that its monitoring requirements involved ‘unexpectedly burdensome administrative tasks’ (Yeandle and Wigfield 2011b, p. 82).

As voluntary organisations play a greater role in society and in delivering public services, they face greater scrutiny. Government and funders expect voluntary organisations to demonstrate their impact, in terms of both value for money and social value (Teasdale et al 2012). Legislation, including the Public Services (Social Value) Act 2012, requires commissioners and voluntary organisations to evidence the social impact of their services, while at the same time there has been a drive for increased impact measurement from voluntary organisations themselves (Harlock 2013; Lumley et al 2011; Fyfe 2005; Anheier and Kendall 2002). Previous research indicates that, largely because of funders’ requirements, voluntary organisations have increased their monitoring and evaluation activities (Arvidson and Kara 2014; Ogaìn et al 2012; Ellis and Gregory 2008) but often face challenges in demonstrating impact due to insufficient resources, lack of necessary skills, unrealistic targets or measurements, competing data collection requirements or inadequate resources to undertake them (Arvidson and Kara 2014; Ogaìn et al 2012; Ellis and Gregory 2008).

Ogaìn et al (2012) surveyed nearly 1,000 UK charities, finding that 60% felt there was insufficient funding for impact measurement and 20% felt collecting data interfered with their relationships with clients; others felt they lacked the correct skills and expertise to monitor and evaluate services (61%) or did not know what to measure (50%) or how to measure impact (53%). Arvidson and Lyon (2013) found that some voluntary organisations use monitoring and evaluation as a form of resistance, noting four main ways organisations can respond to demands for impact evaluation: acceptance, rejection, compliance and ‘strategic decoupling’ (the process of making commitments to satisfy funders while in practice following a different trajectory (Turco 2012; Asdal 2011; Levay and Waks 2009). Staff can decide what information to present in evaluations and to funders, thereby taking some control in the service delivery environment (Arvidson and Lyon 2013).

As this chapter has shown, partnership working (and the mutualism and autonomy it involves) is important for understanding how voluntary organisations promote carers’ work-care reconciliation (Wigfield and Marangozov 2014; Yeandle and Starr 2007; Formby and Yeandle 2005; Arksey 2003) and has become a common contractual obligation for organisations delivering publicly-funded services (HM Government 2011). Delivering publicly-funded services within a marketised system, however, can result in increased competition between providers (a potential factor in reducing trust and collaboration). Organisations delivering the CwC programme, for example, reported issues in forging partnerships and some staff raised concerns about increased competition and reduced collaboration when a second wave of providers was introduced (Yeandle and Wigfield 2011b).

Evidence from the wider voluntary sector, based on Buckingham’s study of the experiences of homelessness service providers in Southampton (2009), finds that the increasingly competitive environment in which organisations deliver services has hindered partnership working, with several organisations bidding for the same funding. Milbourne (2009) also argues that current public service commissioning arrangements impede partnerships and collaborations developed informally and based on trust. Rees et al (2012) found that for the voluntary organisations in their study of partnership working, the public service delivery landscape had a direct impact: the commissioning structure in public service delivery, with prime providers and subcontractors, made it difficult for relationships of trust to develop, and when commissioners mandated partnerships this hindered the development of relationships characterised by trust and reciprocity making mergers particularly difficult to achieve, mainly for reasons of organisational culture and integration. Some other research echoes these findings (Harris et al 2002; Mather 2000). Harries et al (2002) found that mergers can result in shifts in organisational culture and objectives which distance organisations from service users and stakeholders. The changing environment in which voluntary organisations operate, and an increasingly competitive environment which makes partnership working and developing relationships of trust more difficult, has implications for their ability to deliver services in line with an ethic of care, or to promote carers’ work-care reconciliation.

Some authors feel this context is blurring the boundaries between sectors (Civil Exchange 2016; The Baring Foundation 2014, 2013; Aiken and Bode 2009; Carmel and Harlock 2008; Charity Commission 2007; Wolch 1990). Wolch’s (1990) ‘shadow state’ thesis, argues that delivering public services, and reliance on contracts, limits the extent to which organisations can challenge the state and advocate social change. In Cairns et al’s (2010) study, some voluntary sector staff in advocacy roles felt they were unable to fully accomplish their aim of representing the will of the public and of communities, as government was providing their funding (Cairns et al 2010; Shared Intelligence 2008). The Baring Foundation has warned of a loss of the independence in civil society, which (it argues) is crucial to ensuring public trust and enabling it to hold the state accountable and argues that civil society is losing its independence in relation to voice, purpose and action. It emphasises that those who are most affected by these changes are often the most vulnerable in society (The Baring Foundation 2014).

Changes in the environment for civil society threaten its forms, norms and space, with implications for its ability to promote carers’ work-care reconciliation. Voluntary organisations are increasingly delivering publicly-funded services within a competitive environment which is not conducive to partnership working or developing the relationships of trust which are central to an ethic of care, and which enable voluntary organisations to promote carers’ work-care reconciliation. If civil society loses its independence from the state, its ability to represent carers’ voice and to engage with carers may be curtailed, and the changes to the organisational culture of voluntary organisations may diminish the public’s trust. Past studies have indicated that competent staff are important and that short-term contracts and insecurity within voluntary organisations create difficulties in staff recruitment and retention. A shift to delivering publicly-funded services may also reduce the appropriateness of services for carers, and changes to civil society may limit the ability of organisations to deliver services in line with the principles of an ethic of care.

## 3.7 Summary

This chapter argues that the concepts important for understanding the role of voluntary organisations in promoting carers’ work-care reconciliation are civil society, policy implementation, partnership working, social inclusion and sustainability. It indicates that these concepts defined in relation to an ethic of care, can help in understanding the role of voluntary organisations in supporting carers. Civil society is a useful concept for explaining how and why voluntary organisations can promote carers’ work-care reconciliation, and the chapter has argued that the forms, norms and space of civil society are conducive to delivering services in line with an ethic of care.

The chapter also demonstrates that voluntary organisations promoting carers’ work-care reconciliation face many challenges to sustainability. The changing role of voluntary organisations in delivering publicly-funded services, and the increasingly competitive environment in which they operate, is associated with the erosion of the independence of civil society, voluntary organisations and norms of trust and reciprocity. The attributes of civil society which make it conducive to delivering services in line with an ethic of care, and thus to promoting carers’ work-care reconciliation, are under threat.

Studies which have considered the role of voluntary organisations in promoting carers’ work-care reconciliation have mostly been evaluations of specific programmes, rather than explorations of the wider role of voluntary organisations and of civil society in work-care reconciliation. In-depth case studies have been undertaken but have lacked a longitudinal focus or on-going observation of how voluntary organisations promote carers’ work-care reconciliation in practice, and with what impact. Sustainability has been raised as an issue by several authors, but previous studies have not examined how challenges to sustainability are negotiated in practice over time. These gaps in the literature are addressed in the chapters of the thesis which follow.

# Chapter 4: Researching the role that voluntary organisations can play in promoting carers’ work-care reconciliation

## 4.1 Introduction

Chapters 2 and 3 examined previous research regarding work-care reconciliation and the role of voluntary organisations in promoting carers’ work-care reconciliation and identified gaps in the literature to be addressed in the thesis. This chapter outlines the theoretical approach, methodology and research design used to undertake the empirical research. It discusses the ethic of care perspective which informed the study and demonstrates why a mixed methods approach, constructivist grounded theory, and a single longitudinal case study were appropriate to answer the research questions. The chapter outlines the research methods used, which included: tracking ten carers; semi-structured interviews; observation and participant observation; a discussion group; documentary analysis; and analysis of quantitative monitoring data. The chapter also considers the data analysis techniques used, ethical considerations, reflexivity in the research process, and the limitations of the research design.

## 4.2 Research questions

The previous two chapters identified gaps in the literature to be addressed in the thesis. They demonstrated that the specific role that voluntary organisations can play in promoting carers’ work-care reconciliation remains under-researched, as well as how voluntary organisations providing work-care reconciliation support can negotiate sustainability in practice. Previous research does not attempt to theorise the relationships important for understanding the role voluntary organisations can play, and longitudinal research is also lacking. To fill these gaps in the literature, the following research questions are addressed in the thesis:

1. What role can voluntary organisations play in promoting carers’ work-care reconciliation?
2. How can voluntary organisations promote work-care reconciliation in a way which benefits both carers and employers?
3. What are the challenges to sustainability that voluntary organisations providing work-care reconciliation support can face? and how can organisations negotiate these challenges in practice, over time?

The following sub-questions are examined through the case study:

* To what extent did the CReate project provide a support service from which both carers and employers benefitted?
* What were the characteristics of carers who accessed the project?
* What impact did carers’ involvement have on their decisions and behaviour regarding work and care?
* How were the design and implementation of the CReate project, and its outcomes, affected by the funding and public policy context within which it operated?
* Over the lifetime of the project, how and why did the relationships between CReate project staff and other organisations involved shift and change?

##  4.3 An ethic of care, mixed methods and constructivist grounded theory

An ethic of care perspective informed the study. An ethic of care is ontologically relational and recognises that relationships and interdependencies are central to human existence (Tronto 2013, 1993). According to an ethic of care perspective, agency develops through social interaction (Williams 2002). Humans are not passive to their surroundings but make active choices (albeit within structural constraints) (Williams 2002). The epistemological assumptions of an ethic of care advocate emphasising the voices and views of participants, whilst also taking difference into account (Barnes 2012; Williams 2002; Tronto 1993). A relationship of trust and reciprocity should be developed with participants (Sevenhuijsen 1998) and researchers should recognise that care is an ongoing process, which shifts and changes over the life-course, but also occurs within a particular context and is affected by macro processes (Williams 2010; Held 2006; Kittay 1999). In line with this perspective, it was important to emphasise the voice and experiences of participants, gain an in-depth understanding of their perspectives, and incorporate a longitudinal perspective. It was also necessary to focus analysis on the relationships important for understanding the role voluntary organisations can play in promoting carers’ work-care reconciliation and consider the interaction of the macro, meso, and micro.

A mixed methods approach was chosen as the most appropriate to answer the research questions, in line with my epistemological and ontological position. Although some authors have equated feminist research with qualitative methods (Graham 1983; Mies 1983), several authors recognise the value of mixed methods for feminist research (Hesse-Biber 2012; Westmarland 2001; Oakley 1998). Mixed methods research advocates the use of both qualitative and quantitative methods, under the assumption that this will result in a more in-depth understanding of the phenomenon studied (Bryman 2014). According to Kelle (2005), mixed methods are particularly effective when examining broad questions and when considering both the micro and macro levels of analysis. Mixed methods research can be integrated, sequential or parallel (Cresswell 2003). An integrated approach was used for the study, and qualitative and quantitative data were collected concurrently, to examine the same research questions (Cresswell 2003). The study focused, however, on qualitative data, to emphasise the voices and experiences of participants, and quantitative data was supplementary[[27]](#footnote-27) (Mason 2002). A mixed methods approach enabled an in-depth view of the role voluntary organisations can play in promoting carers’ work-care reconciliation to be developed.

Data was collected and analysed based on the principles of constructivist grounded theory. Constructivist grounded theory builds on the foundations of classical grounded theory, developed by Glaser and Strauss (1967). Classical grounded theory outlines a method to develop an in-depth explanation of a particular social phenomenon, by developing theoretical concepts through systematic data collection (Glaser and Strauss 1967). Time and change are central to classical grounded theory; social phenomena are not viewed as static, but as continually changing in relation to the environment (Glaser and Strauss 1967). Grounded theory in its initial conception, however, does not emphasise the views and voices of participants, or consider context (Charmaz 2014; Strauss and Corbin 1990). The researcher is also an objective observer (Glaser and Strauss 1967). Constructivist grounded theory, on the other hand, and especially as developed by Charmaz (2014, 2008, 2006, 1996), emphasises the centrality of participant’s voices, recognises the importance of context and social structure in developing theoretical concepts, and acknowledges that the researcher affects the research process. Constructivist grounded theorists also recognise that researchers are not a ‘tabula rasa’ when they enter the field and advocate the scrutiny of prior knowledge and theoretical perspectives (Charmaz 2008). According to Charmaz (2014), constructivist grounded theory has four principal assumptions:

1. There are multiple realities which are processual and constructed under particular conditions
2. The research process emerges through interaction
3. The positionality of the researcher as well as research participants are considered
4. Data is co-constructed between the researcher and participants and the researcher affects the research situation in accordance with their position, privilege, perspectives, and interactions.

The study data were collected and analysed according to these suppositions. Constructivist grounded theory enabled development of theoretical concepts regarding the role voluntary organisations can play in promoting carers’ work-care reconciliation, in-keeping with my ontological and epistemological position. Although grounded theory is often equated with qualitative research, quantitative data can also inform grounded theory studies (Charmaz 1996). Theoretical constructs developed are grounded in the views and experiences of participants, take time and change into account, and incorporate micro, meso, and macro levels of analysis. Section 4.6 examines how the principles of constructivist grounded theory were used to collect and analyse the data generated from the study.

## 4.4 Research design: longitudinal case study

A single longitudinal case study was chosen as the most appropriate research design to answer the research questions, in line with the theoretical and methodological positioning of the thesis. Although there is no one definition of a case study, several authors agree it involves the in-depth study of a phenomenon or programme, in all its complexity, and in its real-life context (Yin 2011, 1994; Geering 2007; Stake 2005, 1995). Single case studies have several advantages over other strategies as they can: explain complex causal links in real-life interventions; effectively answer ‘how’ and ‘why’ questions; illuminate broader societal trends through studying the particular; generate an in-depth understanding of a specific programme or phenomenon; allow for contemporaneous research over a significant period of time; include all levels of analysis; build theory from in-depth empirical evidence; and be flexible in terms of research methods and approach (Milbourne and Cushman 2013; Simons 2009; Yin 2009; 1994; Geering 2007; Stake 1995; Eisenhardt 1989). As the study sought to build an in-depth understanding of how one voluntary organisation delivered work-care reconciliation support, undertake contemporaneous research, and develop theoretical concepts regarding the role voluntary organisations can play in promoting carers’ work-care reconciliation, a single case study was a highly appropriate research design.

Longitudinal research also has several advantages, including the ability to: examine the relationship between individuals, services, policy and structure; take the micro, meso and macro levels into account in analysis; explore change over time whilst taking the context into account; and develop an in-depth view of a phenomenon in practice (Clark and Fox 2012; Corden and Millar 2007; Lewis 2007; Molloy et al 2002; Neale and Flowerdew 2003). As Neale and Flowerdew (2003, p.190) state:

“It is only through time that we can discern how the personal and social, agency and structure, the micro and macro dimensions of experience are interconnected and how they come to be transformed; for these connections have an essentially dynamic nature”.

Yin (2014, 2011, 2008, 1994) and Stake (1995) identify several types of case study. According to Yin (2014), case studies can be descriptive, exploratory, illustrative, explanatory or evaluative. Stake (1995) outlines a further three types of case study, intrinsic, instrumental and collective. An instrumental case study was used for the study. Instrumental case studies examine the particular to illuminate wider issues and build theory (Stake 1995). For Stake (2005, 1995), case studies cannot be representative, nor should they aim to be. The researcher chooses a case for its potential to maximise learning opportunities and if they have sufficient access (Stake 2005, 1995). The CReate (Carers’ Resource Employment, Advice and Training) project[[28]](#footnote-28) was the case study examined. The CReate project aimed to support carers to combine work and care, or return to work, and to work with employers to create carer-friendly workplaces (Carers’ Resource 2012). The CReate project was one of the services provided by Carers’ Resource, a well-established and successful organisation that supports carers and offers a wide range of services across West and North Yorkshire. Carers’ Resource had successfully delivered work-care reconciliation support for over 15 years and the 2008 National Carers’ Strategy included one of its projects as an example of best practice (HM Government 2008). The study formed part of a collaborative project with Carers’ Resource and the collaboration arrangement included access to project, records, and clients (carers and employers) who utilised CReate project services.

The CReate project provided a unique learning opportunity and information-rich, instrumental case study, through which to examine the role voluntary organisations can play in promoting carers’ work-care reconciliation. A single longitudinal case study enabled an in-depth insight into how a voluntary organisation supported carers to be developed and illuminated wider trends regarding work-care reconciliation and the role of voluntary organisations in society. This research design also enabled the relationships which enabled or constrained carers’ work-care reconciliation to be examined, whilst considering the context. It provided insight into the challenges to sustainability voluntary organisation can face, and how these can be negotiated in practice over time.

## 4.5 Research methods

Multiple methods were used to conduct the case study, including: tracking ten carers as they progressed through the project and beyond; semi-structured interviews with all relevant stakeholders; ongoing observation of CReate project activities (including participant observation); documentary analysis; group discussions; and analysis of quantitative monitoring data. Using multiple methods enabled an in-depth understanding of the case study in practice to be developed. It also helped establish triangulation, ensure the reliability of data, and assist in overcoming issues of researcher bias[[29]](#footnote-29) (Silverman 2009; Denzin 1970). Initially, a month of ‘immersion’ was undertaken (November 2013) at Carers’ Resource and with the CReate project in particular. This enabled rapport to be established with members of staff. Completing the formal induction process for new members of staff also provided insight into the governance of the organisation, its different funding streams, and organisational values. Approximately two days a week were spent with the CReate project for two and a half years (December 2013 – June 2016). The following section outlines the research methods used, and how data regarding different groups of participants was collected.

**Semi-structured interviews:**

As interactions are central to social reality, it was important to understand people’s views and experiences (Tronto 1993). Semi-structured interviews were undertaken with all relevant stakeholders, including: carers and employers who accessed the project; CReate project staff and volunteers; relevant Carers’ Resource staff; and representatives from partner organisations. According to Charmaz (2014, p.87), interviewing provides, ‘the major tool for generating focused data for developing abstract conceptual categories’. Qualitative interviews also give control to participants and can often represent their perspectives more fully, and fairly, than other methods, such as surveys and structured interviewing (Mason 2002). In accordance with the ontological and epistemological position of the study, interviews were co-constructed with participants. In total, 43 interviews were carried out with 35 participants. Table 4.1 outlines the stakeholders interviewed[[30]](#footnote-30).

Table 4.1 CReate project stakeholders interviewed

|  |  |
| --- | --- |
| **Stakeholders interviewed**  | **Interviews undertaken**  |
| **Carers (15)**  | Five retrospective interviews with carers who had accessed the CReate project.Eight prospective and ten retrospective interviews undertaken with ten carers tracked through the project |
| **Employers (5)**  | **Large public-sector organisation*** Two line managers

**Higher education provider*** Line manager

**Enterprise voluntary organisation*** Line manager

**Financial institution** * Line manager
 |
| **CReate project staff and volunteers (7)** | * CReate project manager (1)
* CReate project advisers (4)
* CReate project volunteers (2)
 |
| **Carers’ Resource staff (4)** | * Carers’ Resource Director
* Trustee
* Information team manager
* Caseworker team manager
 |
| **Partner organisations (4)** | **Employment agency*** Employer and Partnership Team member
* Social Justice Team member

**Local authority*** Employee

**Funding body*** Grant Manager
 |

**Observation and participant observation:**

As interviews cannot fully re-construct relationships and interactions, it was important to undertake observation and participant observation (Mason 2002). Participant observation in particular enables a relationship of trust to develop between the researcher and participants, and provides in-depth insight into, and detailed description of, events (DeMunck and Sobo 1998). Observation also enables an understanding of what it is like to be in a particular setting to be developed (McNaughton Nicholls et al 2013). An ‘observer as participant’ stance was adopted for the majority of CReate project activities with carers observed, where the researcher participates in core activities, but those observed are aware of the role of the researcher (Bryman 2014; Gold 1958). Ensuring carers were aware of the aims of the study at the beginning of observations helped to establish relationships of trust. It was also important to be reflexive in interactions, examined in Section 4.7.

Observations were undertaken over a period of just over two years (Dec 2013 - April 2016). Initially, all CReate project activities were observed, as well as several other Carers’ Resource activities, to gain an in-depth view and understanding of the services delivered. Table 4.2 outlines the principal observations of specific activities undertaken. As approximately two days a week were spent with Carers’ Resource, the challenges CReate project staff faced were also observed. CReate project staff meetings, Carers’ Resource locality meetings and Carers’ Resource staff away days (where staff discussed the future direction of the organisation) were observed. As data collection progressed, observations became increasingly targeted, according to concepts which emerged through data collection (examined further in Section 4.6). Field notes were kept of all observations. It was often inappropriate, however, to take notes during observations as this would have made participants feel uncomfortable. As a result, key words were noted and field notes were written up electronically immediately after, or as soon as possible, after observations.

Table 4.2 Specific Carers’ Resource and CReate project activities observed:

|  |  |
| --- | --- |
| **One-to-one sessions with carers**  | * Several observations of one-to-one sessions between CReate project staff and carers
 |
| **Training sessions for carers** | * Beginner’s IT group - six week course of weekly two hour sessions
* Improver’s IT group - six week course of weekly two hour sessions
* Managing Stress - one two hour session
* Building confidence - one two hour session
* Exploring Enterprise - one two hour session
* Enterprise Club - three observed - held monthly for two hours
 |
| **Carer events**  | * Pop-up shop for carers - three training events and one day in the shop
 |
| **Employer events, training and meetings**  | * Awareness raising events held with employers
* HRH Princess Anne visit - employers invited
* Training for line managers carried out with one organisation
* Meetings held with employers accessing CReate project services - with four organisations
* Open days held for employers
 |
| **Internal meetings**  | * Regularly attended monthly locality meetings of the organisation as well as CReate project team meetings
* Employers advisory group which ran quarterly
 |
| **Outreach activities** | * Several awareness raising events at GP surgeries, local shopping centres and with other local voluntary organisations
 |

**Documentary analysis:**

Documentary analysis was undertaken alongside interviews and observation. Documents provide a rich source of data, especially when undertaken in conjunction with observation and interviews (Denzin 1989; Punch 2005). Access to all CReate project paperwork formed part of the collaborative agreement. Documents analysed included: Carers’ Resource bid for funding; CReate project monitoring reports and evaluations; client records; and project materials. This enabled the aims of CReate project services to be examined, as well as the progress of the project, the characteristics of carers who accessed the project and how data regarding the project was reported and what was included. Analysis of CReate project client records provided the perspective of CReate project staff regarding interactions that had taken place. It was important, however, to consider the context and purpose for which the documents were produced (Mason 2002).

**Quantitative data:**

Initially, it was planned to undertake quantitative analysis of CReate project monitoring and evaluation data regarding the characteristics of carers who accessed the project, the services they accessed, and reported outcomes, using data collected by Carers’ Resource and CReate project staff and a two-part evaluation questionnaire. The monitoring data that Carers’ Resource collected included a referral form for each carer who accessed the organisation. This was completed by administration staff and provided the opportunity to collect data regarding carers’ characteristics such as age, gender and ethnicity as well as caring responsibilities, employment status and whether a carer’s assessment had been completed. CReate project staff also had a monitoring form to complete during the first one-to-one appointment with carers. This collected baseline data, including how confident carers feel searching for and applying for jobs, to what extent they feel socially isolated, and to what extent they feel they have a life of their own outside of caring, on a scale of one to five. During each one-to-one session, the CReate project adviser recorded an overview of activities completed in each session and an action plan with tasks the carer was to complete for the next session.

At the end of a carer’s engagement with the project, CReate project staff were to post an evaluation form to carers, which returned to the same questions asked initially, to establish whether carers reported a change in their abilities or circumstances after accessing the project. The evaluation form also included open questions where carers could comment on their overall experiences of the project, and what they felt the impact had been for them. The evaluation form was developed with the CReate project manager at the beginning of engagement with the project. Carers’ Resource and CReate project staff were to collect this data as part of their monitoring processes and make it available. Combined, this data would have provided an overview of the characteristics of carers who accessed the project and the ‘distance travelled’ by carers. Multivariate analysis could have been undertaken regarding the relationships between variables. There were several barriers, however, to collating the quantitative data in practice. Due to time constraints, administrative staff did not always record all information regarding carers; information regarding carers’ employment status, education level, and other services accessed, was often incomplete. CReate project staff did not often ask carers to complete the baseline data monitoring information, as they felt they were asking carers to fill in too much paperwork. With high staff turnover, CReate project staff did not prioritise monitoring forms and often did not complete them (see Chapter 8 for further discussion). CReate project staff also stated they found it difficult to discern a perceptible ‘end’ to carers’ engagement with the project, and so to ascertain when to send evaluation forms.

One CReate project adviser initially sent out the evaluation forms, although when they left the organisation, this responsibility did not pass to a new member of staff. Again, with high staff turnover and disruptions to the project, CReate project staff prioritised generating referrals and delivering services, not sending evaluation forms. When new staff members were asked regarding the evaluation forms and whether they had had any returns, they stated they were not aware of the evaluation form and had not been asked to use it by the CReate project manager. In response, the CReate project manager stated as the return rate had been so low previously, she did not feel it was worth sending. The CReate project manager also felt that ‘case studies’ of carers who accessed the project provided a better picture of carer outcomes for the funder than quantitative data (see Chapter 8 for further discussion). Different members of staff recorded monitoring data differently and each developed their own way of working and own way of recording information. Each carer had a paper record, with, in theory, the initial referral form filled in by administration staff, the initial CReate project monitoring form, CReate project staff records of services delivered, and actions taken by them and the carer. Staff also had their own spreadsheets, where they recorded some details of clients, and an overview of services delivered. CReate project staff only kept detailed records regarding carers who accessed one-to-one support and not for those who accessed only workshops (see Chapter 5, 5.2). Approximately half way through my data collection, Carers’ Resource introduced a new organisation-wide electronic database. Gradually, Carers’ Resource and CReate project staff started recording all information regarding carers and the services they accessed on the database. However, this took time to introduce, and whilst some staff used it straight away to record data, others took time to start using it. In order to save time, information initially inputted by administration staff also became minimal. CReate project staff did use the database to a certain extent, but predominantly used their systems already in place; paper records and spreadsheets.

CReate project monitoring data available from CReate project client records and staff spreadsheets were collated using Excel. This provided an overview of the number of carers who accessed the project, their characteristics, the services they accessed, and outcomes recorded by CReate project staff, such as whether a carer entered employment, further training or volunteering, after accessing the project (see Chapter 5). It was not possible, however, to measure the ‘distance travelled’ of carers in terms of whether they gained confidence or felt less socially isolated after accessing the project. There were also limitations to the monitoring data available, and variables such as the number of hours of care provided per week, whether a carer is co-resident, and how long they have been a carer for, were not recorded. Carers’ Resource staff and a volunteer completed the evaluation of the CReate project (required by its funders, the BIG Lottery) (Carers’ Resource 2016). BIG Lottery required CReate project staff to report and evidence the extent they had met initial targets set (see Chapter 5).

Carers’ Resource used some of the data from the study to provide additional information within the BIG Lottery evaluation regarding the processes important for understanding what enabled carers to pursue their goals around work, learning and training. As the evaluation was constructed specifically to report to funders regarding pre-agreed targets, it was important to collate and evaluate CReate project monitoring data separately from that of the Carers’ Resource evaluation (see Chapter 8 for further discussion). Slightly different results regarding the numbers of carers who accessed the project and CReate project staff’s reported outcomes were obtained (see Chapter 5). The data collated and evaluated for the study are referred to in the thesis.

In hindsight, it would have been beneficial to develop a reporting form for CReate project staff to complete at the beginning of a carer’s engagement, which would have captured baseline data including all factors such as the characteristics of carers, their confidence levels, to what extent they felt socially isolated, and what they were hoping to gain from the project, as well as information needed for BIG Lottery monitoring and evaluation. Responsibility could also have been taken for sending evaluation forms to carers when their engagement with the project came to an end, rather than relying on Carers’ Resource own data for this, which, in the end, was not available as hoped and expected. Nevertheless, quantitative data collated, provided an overview of the numbers and characteristics of carers who accessed the project, the services they accessed, and CReate project staff reported outcomes.

**Carers:**

Initially, five retrospective interviews were undertaken with carers who had accessed the project to establish concepts important to explore in the in-depth longitudinal research with carers. Carers interviewed were those who had recently ceased engagement with the CReate project, so their memories and experiences of the project were recent. Carers interviewed were those CReate project staff felt had had a ‘positive outcome’, such as returning to work, as well as those who had faced difficulty achieving their goals. This was to gain an understanding of the processes which promoted carers’ work-care reconciliation, and those which potentially hindered it. Three carers interviewed had returned to work and two were combining work and care but were struggling to do so. Interviews were conducted in a private room in Carers’ Resource offices.

A timeline tool was used to establish caring, education and employment histories, as well as any significant life events. Carers were asked to plot developments in their education and employment histories on one side of the timeline, and their caring responsibilities and key life events on the other. This enabled carers’ historical caring and employment trajectories to be plotted, from which critical junctures could be identified and discussed further. One carer, for example, had a significant career change and probing further, she reported that her caring responsibilities had significantly intensified around this time and was finding it difficult to care for her husband and work full-time. Timelines, and the knowledge generated from them, however, were greatly dependent upon the memories of carers. These interviews also explored the reasons for contacting the CReate project and carers’ initial aims when they accessed the project. Additionally, carers’ experiences of CReate project services, the impact of accessing the project, and deficiencies in services were examined[[31]](#footnote-31).

**Tracking Ten Carers**

Ten carers were tracked as they progressed through the CReate project, and beyond, to gain an in-depth view of the CReate project services carers accessed, the experiences of carers, and the impact (if any) of the project. According to Eisenhardt (1989), between four and ten cases are optimum for building theory with adequate complexity and sufficient grounding in evidence. With their permission, the first couple of appointments a carer attended with the CReate project were observed and informal conversations were had with carers regarding their caring responsibilities, previous employment and education, and aspirations regarding work and care. This enabled information-rich cases to be selected (Stake 1995). Sampling was initially purposive and carers with a range of caring responsibilities and educational and employment histories were asked to participate. Gender, ethnicity, and hours of care provided, were also considered, as these factors have been shown to affect the experience of carers’ work-care reconciliation (Carmichael et al 2010; Heitmueller 2007). All carers approached to participate cared for more than ten hours a week. The sample was not representative but included carers with a variety of characteristics and caring responsibilities. Table 4.3 outlines the characteristics of the ten carers tracked through the project and the pseudonyms used throughout the thesis.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Carer pseudonym**  | **Gender** | **Age\*** | **Ethnicity** | **Cared for**  | **Co-resident** | **Highest educational level**  |
| **Pat** | Female | 50-59 | White British  | Son with autism  | Yes | Undergraduate degree |
| **Clare** | Female | 50-59 | White British  | Son with autism and behavioural problems | Yes | A-Levels |
| **Rachel** | Female | 50-59 | White British  | Daughter with mental health problems | No | Diploma  |
| **Lawrence** | Male | 60-65 | White British  | Mother who was frail and limited mobility | No | Undergraduate degree |
| **Natasha** | Female | 35-49 | White British  | Uncle with long-term illness and mobility problems | No | GCSEs |
| **Louise** | Female | 35-49 | White British  | Mother with limited mobility | No | Undergraduate degree |
| **Carol**  | Female | 60-65 | White British  | Friend/housemate with autism  | Yes | General secondary education  |
| **Barbara** | Female | 50-59 | White British  | Mother with limited mobility and frail | No | Undergraduate degree |
| **Frank** | Male | 50-59 | White British  | Wife with long-term illness | Yes | A Levels |
| **James** | Male | 35-49 | White British  | Father with substance misuse problems and frail | No | Doctorate |

Table 4.3 Characteristics of carers tracked through the project:

\*This refers to the age of carers when they first accessed the CReate project, they may have been within a different age bracket at the end of their participation in the research.

The majority of carers tracked were female (7), although three male carers were also included in the study. Although feminist research is often ‘for women, by women’, it was also important to understand the experiences of men as enabling men to combine work and care is essential for gender equality in relation to work and care (Lewis 1997). The majority of carers tracked (8), had moderate levels of caring responsibilities (1-19 hours a week). One had substantial caring responsibilities (20-49 hours a week) and one, intensive (over 50 hours a week). Carers tracked were also slightly older than carers of working age nationally as five were aged 50-59 at the beginning of their participation, two aged 60-64, and three aged 25-49 (ONS 2011). Four participants cared for a parent, three for a child, one for a partner, one for a friend and one for another relative. The majority cared for someone who was frail, had limited mobility or had a learning disability. Two cared for someone with a mental health problem and one for someone who had mental health and substance misuse issues.

Those tracked through the project had fairly high education levels and four were educated to degree level or higher, three had two or more A Levels (or the equivalent), two had five good GCSEs (or the equivalent) and one had no formal qualifications. All carers tracked through the project were White British, which is a limitation to the data as ethnicity is an important factor to consider in relation to work-care reconciliation (Yeandle et al 2007a). Although CReate project staff engaged with a relatively high number of Pakistani carers (see Chapter 5), it was difficult to recruit carers from a non-white British background. Conversations with CReate project staff and observations indicated that Pakistani carers often preferred to have home visits, and some were not comfortable with a researcher attending their home. CReate project staff also found it difficult to engage with BAME communities and did not want to jeopardise their engagement with carers, which they sometimes felt a researcher’s presence might do, in particular during one-to-one support sessions.

Carers were approached to participate in the study after observing one or two of their appointments with CReate project staff. This enabled rapport to be established. Carers who agreed to participate were then interviewed as soon as possible. Only one carer approached did not wish to participate. These initial interviews followed a semi-structured approach[[32]](#footnote-32). The timeline tool was used to establish caring and employment histories. Interviews then considered where carers had heard about the CReate project, why they decided to access it, and the aspirations regarding work and care (which were then returned to in follow-up interviews). Carers were asked regarding their expectations of CReate project services and staff and whether they were accessing any other support services. Although interviews were undertaken as soon as possible after the first appointment and carers’ initial engagement with the project, this was not always possible. In two cases it took a while to establish rapport and for the carer to agree to participate, so that by the time the initial interview was arranged, they had already accessed another appointment or activity (although these were observed).

Following these initial interviews, all appointments, activities, and services carers attended were observed (where possible). Several informal conversations were also had with participants before and after appointments and activities. Participants’ engagement with the CReate project varied considerably and whilst some carers attended weekly appointments for a month, others had bi-monthly appointments for two years or more. Table 4.4 outlines the services and activities carers accessed during the data collection period and those observed.

Once a carer’s engagement with the CReate project ended, a follow-up interview was arranged, which examined carers’ experiences of the CReate project, and the impact they felt the project the first and follow-up interviews to be determined, as well as whether carers’ decision-making regarding work and care had changed. The aspirations carers raised in the initial interview were returned to, and to what extent these had been realised established. This enabled the ‘distance-travelled’ to be considered. Following the second interviews, correspondence was kept with carers via email for up to two years. This enabled the potential longer-term impact of the CReate project to be established. Tracking ten carers through the project enabled rapport and trust to develop. It provided an in-depth and unique insight into the relationships between carers and CReate project staff over time. It enabled examination of the impact of the CReate project in relation to carers’ decision-making regarding work and care. It also provided data to develop a theoretical understanding of the role voluntary organisations can play in promoting carers’ work-care reconciliation, taking time and change, and the local and national policy context, into account (Research Questions 2 and 3).

Table 4.4 Length of engagement with CReate project, services and activities accessed and activities observed

|  |  |  |  |
| --- | --- | --- | --- |
| **Carer** | **Length of engagement with CReate project**  | **Services/ activities accessed**  | **Services/ activities observed**  |
| **Pat** | 5 weeks  | Three one-to-one appointments  | Three one-to-one appointments  |
| **Clare** | 2 years+ | Two one-to-one appointments  | Two one-to-one appointments  |
| **Rachel** | 1 year+ | Four one-to-one appointments  | Three one-to-one appointments  |
| **Lawrence** | 1 year+  | Three one-to-one appointments Three group activities (three of the same activity) | Two one-to-one appointments Three group activities (three of the same activity) |
| **Natasha** | 9 months | Three one-to-one appointments Two group activities(two of the same activity) | Three one-to-one appointments Two group activities(two of the same activity) |
| **Louise** | 2 months | Two one-to-one appointments | Two one-to-one appointments |
| **Carol**  | 14 months | Four one-to-one appointments Three group activities (three of the same activity)One six week training course | Four one-to-one appointments One group activityTwo of the training sessions  |
| **Barbara** | 1 year+ | Four one-to-one appointments Three group activities (three of the same activity) | Four one-to-one appointmentsThree group activities (three of the same activity) |
| **Frank** | 18 months | Six one-to-one appointments\*\*  | Three one-to-one appointments  |
| **James** | 3 months | Four one-to-one appointments | Two one-to-one appointments |

\* + indicates engagement with the project had not finished when CReate project funding ended.

 \*\*Frank had already had three one-to-one sessions before I commenced data collection.

**Discussion group**

A discussion group of eight carers, made up of seven carers tracked through the project and one who was interviewed retrospectively, also informed the study. Although all ten carers tracked were invited to participate in the discussion group, three declined as they did not live near Carers’ Resource offices. Those who could not attend contributed via email and their contributions, with permission, were read aloud at meetings. Three meetings were arranged over a year (July 2015-July 2016). The group was formed after all carers had accessed the CReate project for a few months and felt comfortable with the organisation. Different topics were discussed in each meeting. Initially, what work-care reconciliation would look like ideally was examined and issues carers faced combining work and care. Subsequent discussions considered experiences of the CReate project and emerging findings from the research. Trust and reciprocity, for example, emerged as important concepts, and the extent carers found these important were discussed. The discussion group enabled emerging concepts to be confirmed, refuted, and refined, and provided carers with an overview of the research findings.

**Employers**

The ways in which CReate project staff attempted to engage with, and work with, employers, were observed. Several meetings and events were attended and informal conversations held with employers. This provided insight into how CReate project staff delivered services for employers, and the responses and reactions of employers. It also enabled rapport to be established with employers before inviting them to participate in an interview. Four employers from four organisations which accessed CReate project services were interviewed. Only four organisations engaged with the project during the data collection period (see Chapters 5 and 6). Interview topics varied according to the work undertaken between the employer and CReate project staff.[[33]](#footnote-33) Retrospective interviews were undertaken with line managers and other staff, to examine their motivations for accessing the CReate project, their experiences of services, and their perceived impact of services. Key topics which had arisen during observations were also explored.

Interviews lasted for between one hour and one hour and a half and were informed by elite interviewing methods. Carefully prepared interview schedules were used, open-ended questions were asked, and questions moved from the general to the specific (Harvey 2011; Aberbach and Rockman 2002; Beamer 2002). The timing of interviews varied depending on the nature of employers’ engagement with the CReate project as well as the timing of their engagement with the project. For example, interviews with the line manager and an employee at Renford were undertaken nine months after CReate project engagement to ascertain the potential longer-term impact of accessing the project’s services whereas the CReate project engaged with Ulearn towards the end of data collection, so this interview was carried out during their engagement with the project. Table 4.5 outlines the participant organisations and the pseudonyms used in the thesis.

Table 4.5 Employers and pseudonyms

|  |  |
| --- | --- |
| **Organisation type** | **Pseudonym** |
| Large public-sector organisation | Renford  |
| Voluntary organisation | Community Trust |
| Financial Institution | Tradebank |
| Higher education institution | Ulearn |

**CReate project staff**

Data collection also included informal conversations and interviews with CReate project staff. Interviews were carried out with the CReate project manager, four CReate project staff, and two CReate project volunteers. They are referred to in the thesis as the CReate project manager, CReate adviser 1, 2, 3 and 4, and CReate volunteer 1 and 2. Although seven CReate advisers delivered the project over its duration, four advisers delivered the project during the period of d ata collection and CReate advisers 1, 2 and 3 delivered the majority of services observed. Interviews with CReate project staff enabled exploration of the previous work experience of CReate project staff, their motivations for applying for a job at Carers’ Resource, and their aims for delivering services. They also provided insight into the challenges to sustainability the project faced and how staff negotiated them (Research Question 3). The CReate project manager acted as a ‘key informant’ as she had been with the organisation for over 15 years delivering employment support projects and had extensive and in-depth knowledge of the project and organisation (Payne and Payne 2004; Marshall, 1996). She had also played a key role in developing the funding bid for the CReate project and designing the project. Regular meetings and informal conversations with the CReate project manager provided understanding of the development of the project, issues faced, and the wider activities of the organisation.

Table 4.6 CReate project staff interviewed and observed:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CReate project staff** | **Duration with CReate project** | **Age** | **Gender** | **Ethnicity** |
| CReate project manager  | Jun 2013 - Apr 2016 | 50-64 | Female | White British |
| CReate project adviser 1 | Jan 2015 – Apr 2016 | 35-49 | Female | White British |
| CReate project adviser 2 | Jul 2014 - Apr 2016 | 25-34 | Male | White British |
| CReate project adviser 3 | Jun 2013 – May 2013 | 35-49 | Female | White British |
| CReate project adviser 4 | Jul 2014 – Sep 2014 | 35-49 | Male | Asian British |

Three interviews in total were undertaken with the CReate project manager. These interviews partially explored the relationships with other organisations to establish how these shifted and changed over time. Relationships were mapped using an eco-map. Social workers often use eco-maps to explore relationships important to a person, and the nature of these relationships (Healy 2005; Meyer 1993; Hartman 1978). Figure 4.1 provides an example of an eco-map. The eco-map was developed with the CReate project manager as she was the only member of staff to remain in post throughout the project and undertook the majority of partnership work. Initially, the CReate project manager was asked to identify all relevant external partnerships. She was then asked to identify the nature of the partnerships using a key. Double straight lines signified a strong positive relationship, a dotted line a weak relationship and a zig-zag line indicated a difficult or broken relationship. Constructing the eco-map enabled the nature of relationships to be established. The eco-map was returned to with the CReate project manager approximately every six months and three times in total. This enabled new partnerships formed during the project to be examined and whether existing partnerships had changed in their nature (see Chapter 7 for discussion of CReate project partnerships). The eco-map also helped identify partner organisations from which to interview representatives.

Figure 4.1 Example of an eco-map



Two volunteers who delivered training for the CReate project were interviewed. Interviews explored their motivations for volunteering, their previous work experience, and their approach to service delivery. Interviews were also conducted with other key members of staff, including: Carers’ Resource Director; a trustee; a caseworker; and an information team member. CReate project staff worked closely with these staff members. Interviewing the Director provided insight into the role of the Director in the design and implementation of the CReate project, the development of Carers’ Resource, and its organisational values. Interviewing a trustee determined the role of the trustees in ensuring the project’s sustainability and their decision-making process regarding challenges faced. Interviews with the caseworker and information team member enabled the CReate project’s internal partnerships to be explored. Regular informal conversations were also held with Carers’ Resource staff.

**Partner Organisations**

Interviews were conducted with representatives from four partner organisations. These interviews considered the nature of partnerships, their experiences of working with the CReate project, and any barriers to partnership working faced. The CReate project Employers’ Advisory Group of local partner organisations was also observed. This group consisted of relevant local stakeholders from all sectors (public, private and voluntary) and met quarterly to provide advice on the direction of the project and discuss potential collaborative opportunities. Together, the research methods used enabled an in-depth, longitudinal, insight into the ways one voluntary organisation promoted carers’ work-care reconciliation, from which implications about the wider role of voluntary organisations in supporting carers, could be ascertained.

## 4.6 Data analysis techniques

As a constructivist grounded theory approach informed my research: data were collected and analysed simultaneously; conceptual categories were developed; actions and processes were examined rather than themes; and theoretical sampling and constant comparison were used (Charmaz 2014, 2006, 1996). With consent, all interviews[[34]](#footnote-34) were transcribed. All observational notes were recorded electronically. A case study database was developed, organised using Microsoft Word. Observational data was organised chronologically and ten ‘embedded’ case studies of the carers tracked through the project were developed (Yin 1994). Again, data were organised chronologically, so time and change could be examined. Data was initially analysed using open coding Charmaz 2014) and as data collection and analysis progressed, codes were increasingly focused. Open coding consisted of analysing each line using gerunds rather than themes and topics, as constructivist grounded theory advocates (Charmaz 2014). In this way, the theoretical understanding developed focuses on social processes and relationships rather than themes, which was one of the aims of the thesis. Following open coding, more focused coding was undertaken and emerging key concepts were noted to be explored further.

Theoretical sampling enabled emerging concepts to be considered. For example, ‘working in partnership’ became apparent from the beginning of data collection as an important concept for understanding the role of the CReate project in supporting carers. Observations and interviews then paid specific attention to partnerships, the nature of different partnerships and the potential role they had in supporting carers. Theoretical sampling enabled increasingly focused questions to be asked in data analysis and to confirm or refute emergent analytical codes (Charmaz 2005). Data collection and analysis proceeded until ‘saturation’ was achieved and the analytical codes developed were sufficient to explain the data (Charmaz 2014; Holton 2007; Glaser 2001). In this study, saturation referred to sufficient theoretical categories to explain how the CReate project promoted carers’ work-care reconciliation.

Analytical categories were developed through memo writing and using the constant comparative method (comparing and contrasting emergent categories across all data (Charmaz 1995). Data collected regarding the ten carers tracked through the project, for example, were compared and contrasted throughout the study. Carers’ responses in the first and final interviews enabled comparison over time, which Charmaz (2014) states is particularly useful for developing analytical categories. Table 4.6 outlines an example of development from initial coding to focused coding to analytical categories.

The constant comparative method also included comparison with existing research and theories regarding emerging concepts. Emerging concepts from the CReate project informed reading and the literature review chapters (Chapters 2 and 3) were revised following completion of all data analysis to better reflect the concepts that had emerged during data collection. Existing research and theoretical concepts were used to help explain and contextualise the theoretical understanding of the role voluntary organisations can play in promoting carers’ work-care reconciliation developed through the case study of the CReate project. Saldana’s (2003) framework of questions for analysing qualitative longitudinal data also informed data analysis. These include; ‘framing questions’ which locate the study firmly within its context and consider the potential influence of the context; ‘descriptive questions’ which enable you to outline the processes of time and change in a study; and ‘analytic and interpretive questions’ which address why these changes have occurred (Saldana 2003).

Table 4.7 Example of the development of codes in data analysis:

|  |  |  |
| --- | --- | --- |
| **Focused codes**  | **Analytical codes**  | **Analytical category**  |
| Participating in service delivery/ design | Giving carers voice | Social inclusion  |
| Raising awareness of carers |
| Meeting other carers |
| Developing social networks  |
| Recognising carers’ individual situations  | Inclusive diversity  |
| Delivering culturally appropriate services  |
| Engaging with specific communities  |

Quantitative data was analysed using SPSS. It was envisaged that quantitative data would be analysed alongside qualitative data to confirm or refute emerging concepts. Due to the issues with collecting and collating quantitative data, it was analysed at the end of data collection to inform qualitative analysis. This enabled development of conceptual categories and a theoretical understanding of the role voluntary organisations can play in promoting carers’ work-care reconciliation.

## 4.7 Ethical considerations and reflexivity:

The main ethical issues faced in the study related to informed consent, anonymity, and managing relationships. Whilst longitudinal research does not raise different ethical issues to cross-sectional research, it does heighten them (Corden and Millar 2007; Farrall 2006). Ethical issues were addressed using University of Leeds[[35]](#footnote-35) and University of Sheffield ethical guidelines, as well as ESRC’s Framework for Ethics. It was important to gain continued informed consent, rather than once at the beginning of the study (Corden and Millar 2007). All members of staff at Carers’ Resource were aware the research was being undertaken, and continued access to the organisation formed part of the collaborative agreement. For observations of group activities with carers, CReate project staff clearly outlined the aims of the research at the beginning, and carers were invited to ask any questions. With observations of one-to-one support, CReate project staff asked carers at the beginning of sessions whether they would be comfortable being observed and outlined the nature of my research. Prior to observations of events and meetings with employers, the CReate project manager explained my role as a researcher. It was not always possible, or feasible, to gain informed consent, however, when activities such as outreach work and large networking events were observed.

All participants interviewed were provided with an information sheet prior to the interview to ensure they were fully aware of the nature of my research and what participation would involve (see Appendix A.1). It was also ensured that participants read, understood and signed a consent form at the beginning of all interviews (see Appendix A.2). All participants in the research were made aware that they could withdraw from the research any time they wished. Following interviews, transcripts were supplied to all participants, who were invited to make alterations. With carers tracked through the project, consent was sought throughout their participation. Prior to all observations, it was established whether participants were comfortable with me observing and made clear they could withdraw from the research process at any time. Consent was sought again prior to the follow-up interviews. At the end of carers’ engagement with the project, it was confirmed with carers whether they were happy to stay in contact over the following year and their preferred mode of contact determined.

Confidentiality and anonymity were other ethical issues addressed in the thesis. All data collected was confidential and not shared with third parties. For Carers’ Resource and CReate project staff, anonymity was ensured as far as possible and names not used in the thesis. However, as a single case study was undertaken, it may be possible to identify individuals due to their role within the organisation. Carers’ Resource as an organisation gave their permission to be named in the thesis and staff were fully aware of any consequences, positive or negative. Participant carers and employers have pseudonyms and identifying information is not used. Although CReate project staff may be able to identify carers, they are anonymous to the public, and CReate project staff are bound by Carers’ Resource confidentiality regulations. Representatives from partner organisations interviewed are not named.

It was important to consider relationships and managing the ‘exit’ from the research site, particularly as a longitudinal study was undertaken (Neale and Hanna 2012). Although relationships of trust developed with participants, it was ensured that participants were fully aware of the nature of the relationship. When the project’s funding ended, Carers’ Resource held a celebration event to which some carers who had accessed the project were invited. All carers who were participants in the study were invited to attend, and the majority (8) did. The event provided the opportunity to thank participants and Carers’ Resource staff and ‘officially’ marked the end of my data collection. Research findings from the study were also presented. Following the event, contact was maintained with carers tracked through the project via email. Contact with some naturally ended as a couple of carers moved away and some have not replied to emails. Occasional email contact has been continued with a few carers.

It was also important to ensure reflexivity in the research process and consider and acknowledge the role of the researcher. Reflexivity can reveal relationships of power, create relationships that are equal and highlight ethical concerns (Hesse-Biber and Piatelli 2012). Keeping a research diary was the principal way reflexivity was achieved. This provided a systematic way to reflect on the research process (Nadin and Cassell 2006). The research diary was kept separate from field notes and was used to reflect on the research process. As soon as possible after each data collection activity (usually on the train home), reflections regarding any practical issues in data collection and experiences were recorded.

As an in-depth case study of one voluntary sector project was undertaken for the empirical research in this thesis and a significant amount of time was spent with research participants and with the staff of the case study organisation, it was important to manage any potential impact on the research participants and setting. With carers, establishing rapport and gaining consent initially was essential and enabled trust to be developed. Interviews with carers commenced with open questions regarding their caring responsibilities and employment history which allowed carers to share their ‘story’. At the same time, it was ensured that carers understood they should not discuss anything they didn’t want to or found upsetting. This helped mitigate the potential negative impact of participating in the research. Several participant carers also emphasised their appreciation for the opportunity to share their experiences. The presence of a researcher could also have impacted the behaviour of CReate project staff and the way they delivered services. It was important to ensure that Carers’ Resource staff understood the purpose of the research and that the aim was not to evaluate and scrutinise the effectiveness of their services, but explore how they aimed to support carers and the challenges they faced.

As a significant period of time was spent at Carers’ Resource and with CReate project staff, this enabled rapport and trust to be built, and helped to mitigate the impact of having a researcher present when delivering services, as it became routine. The observer as participant stance adopted within the research also contributed to limiting the impact of the researcher; engaging with carers but not interfering with how CReate project staff delivered services. During group activities observed, for example, it was ensured at the beginning that carers understood the researcher was not a Carers’ Resource member of staff, but at the same time, activities weren’t observed from a corner. Talking to carers and participating by making cups of tea enabled observation, but limited the impact on the participants and research setting. Although CReate project staff may have tried to ensure that services were delivered to the very best of their ability as they were being observed, this would ultimately have a positive impact for carers and the project. It can be said that the impact of participating in the research for participants and the setting was largely positive.

Using the techniques outlined, potential issues regarding informed consent, confidentiality, anonymity and managing research were addressed, and reflexivity in the research process achieved.

## 4.8 Limitations of the research design

There are some limitations to single case study research designs. The main criticism of single case studies is the issue of generalisation and transferability (Yin 1994; Lincoln and Guba 1985). As case studies are context-specific, and purposive sampling is often used, scientific, statistical generalisations to a wider population cannot be made (Gerring 2007). As Stake (1995) states, however, the main aim of case studies is not to generalise, but to highlight the particular, and in doing so, what he terms ‘naturalistic’ generalisation can be achieved by enhancing understanding of a phenomenon and resonating experientially with a wide range of readers. Furthermore, Lincoln and Guba (1985) argue that, although transferability and generalisation in a statistical sense are not possible through qualitative research, by producing an accurate and detailed description of the context, design, and implementation, of a programme, readers can decide for themselves whether it would work for them, or in a different context. Although single case studies cannot provide statistical generalisations, they can produce analytic and naturalistic generalisations. Data generated regarding the CReate project cannot be representative of all voluntary organisations providing work-care reconciliation support, but the theoretical concepts and categories developed can be tested or applied within other contexts.

Case studies have also often been criticised for being prone to selection bias, and some fear the ‘investigator effects’ of case study researchers (Bromley 1986; Becker 1968). As investigators often already have an interest in, or have connections with, the subjects that they study, it can be difficult to avoid bias. Reflexivity and data triangulation, however, can help address bias (Miles and Huberman 1994) and reflexivity in the research process was established and multiple methods used. Internal validity can also be an issue with qualitative and case study research (Yin 2013). According to Lincoln and Guba (1985), however, using appropriate research methods helps overcome issues of internal validity and Shenton (2004) argues that developing familiarity with an organisation from an early stage in the research process is important. Lincoln and Guba (1985) recommend ‘prolonged engagement’ with an organisation and participants to gain an understanding of the organisation and establish trust between all the parties. The month of immersion and ongoing engagement with the Carers’ Resource for over two years provided prolonged engagement. It was important to recognise, however, that becoming too immersed within the organisation could influence or bias research judgements (Mason 2002). Although some of the limitations of case study research are addressed in the thesis, data generated cannot be generalisable to the wider population.

## 4.9 Summary

The chapter highlights the research objectives and research questions addressed in the thesis. It outlines the theoretical perspective and methodology that underpinned the research, and the research design and research methods used to conduct the empirical research. It considers how an ethic of care perspective informed the study and outlines the constructivist grounded theory and mixed methods approach used. The chapter examines why a single longitudinal case study was the most appropriate research design and outlines the research methods used to carry out the study, which included: tracking ten carers; ongoing observation and participant observation; semi-structured interviews; documentary analysis; and quantitative analysis of monitoring data. It also outlines how data was analysed using the principles of constructivist grounded theory and Saldana’s (2003) framework. The chapter considers ethical issues in relation to the research and indicated how the study addressed these. It establishes how reflexivity in the research process was achieved and outlines the limitations to the research design. The following chapter outlines the CReate project, the case study used for empirical research, in further detail.

# Chapter 5: The CReate project; context, aims, operational arrangements and monitoring data

## 5.1 Introduction

The chapter summarises what the CReate project aimed to do and how. It considers the city of Bradford where it was located, including: demographics; characteristics of carers of working age; the local labour market; local voluntary sector; and carer support. The chapter outlines the activities and organisational culture of the Carers’ Resource which delivered the CReate project. It considers the aims of the CReate project and the operational arrangements used to implement services in practice, including an overview of CReate project staff, the activities delivered, and CReate project partnerships. The chapter presents CReate project monitoring data regarding the characteristics of carers who accessed the project, the services they accessed, and outcomes as reported by CReate project staff. The chapter draws on data from interviews with CReate project and Carers’ Resource staff, observations of services in practice, documentary analysis of the initial bid for funding and final evaluation and CReate project quantitative monitoring data.

## 5.2 Bradford: demographics, carers of working age, the voluntary sector and carer support

*Demographics*

The CReate project was based in Shipley, Bradford, and covered the Bradford and Airedale region. The population of Bradford is 528,200 and the majority (over 60%) of the population are of working age (16-64) (ONS 2016). The district has a relatively high proportion of young people and low proportion of older people; nearly one quarter (24%) of Bradford’s population is under 16 and only 14% are 65 and over. Following national trends, however, the very elderly population (over 85) is set to increase by 30% by 2023 (ONS 2016). Bradford has a higher than average level of children and adults with long-term illnesses and disabilities (between 21 and 26%) (ONS 2014). It is an ethnically diverse area and 20% of the population are of Pakistani ethnic origin, the largest proportion in England (ONS 2011). According to Department for Communities and Local Government (DCLG) official data, Bradford has a high proportion of deprived areas and is one of the twenty most deprived local authority areas in England (DCLG 2015). The area has a high unemployment rate and only 65% of the working age population are reportedly in employment, significantly lower than the national average (72%) (ONS 2016). The largest employment sector in the area is health, followed by manufacturing, education, and retail (ONS 2016). Qualification levels of the working age population in the area are below the national average; nearly 14% of people aged 16 and over have no qualifications, compared to 8% nationally (ONS 2016). An increasing number of people, however, are educated to degree level (25% compared with 38% nationally) (BMDC 2013).

*Carers of working age*

50,914 people (almost 10% of the population) in Bradford indicated in the 2011 Census that they provide some form of unpaid care or support for someone due to illness, disability or old age (ONS 2011). In line with national trends, women and people of working age (16-64) provide the most care (ONS 2011). The majority of carers provide moderate amounts of care (1-19 hours a week) although nearly 25% provide 50 or more hours of care a week (ONS 2011). Those who provide over 50 hours per week are more likely to report they are in bad or very bad health (ONS 2011). The 25-49 age group are more likely to provide care in Bradford than in England and a high proportion of carers in Bradford are Pakistani or British Pakistani (ONS 2011) (See Table 5.5 for comparison of carers in Bradford and England). Just over half (51%) of carers in Bradford are in employment (ONS 2011). Nearly 30% are in part-time employment and just over 50% are in full-time employment (ONS 2011).

*Support for carers in Bradford*

Bradford has a local Carers’ Strategy (Caring Matters: Think Carer 2011), developed by Bradford Council and NHS Bradford and Airedale, which outlines how the aims of the National Carers’ Strategies are to be met locally. It identifies supporting carers to return to work or remain in employment, and encouraging employers to support carers in the workplace, as areas in need of development (BMDC and NHS Bradford and Airedale 2011). A range of support services are available for carers in Bradford, mostly funded through the local authority and delivered by voluntary and statutory organisations (BMDC 2017). As of September 2014, Carers’ Resource hold the contract to provide all local authority carer support services for Bradford (the Integrated Carers’ Service, explored further in Chapter 8). Services available include: information regarding any aspect of caring or care; advice on health; support around social and financial needs; support applying for benefits; planning for emergencies; advice and support on applying for a carer’s assessment; and navigating health and social care systems (Carers’ Resource 2018c).

Several condition-specific voluntary organisations also provide support for carers, including peer support and groups, information and advice, and short breaks. A local authority scheme provides breaks for carers and several voluntary organisations provide activities for older and disabled people that provide a break for carers (BMDC 2017).  The Carer’s Small Grant Scheme (now called the Carer’s Wellbeing Grant) provides one-off payments to carers of £200 to contribute to their health and well-being and some GP practices provide health checks for carers (Carers’ Resource 2018b).

Some training opportunities are available for carers in Bradford. First Aid Training is available for parents and carers through a private provider for a small fee (GEM 2017). According to a Carers’ Resource information officer, some voluntary organisations offer courses for carers regarding people handling, managing money, and managing stress. Condition-specific voluntary organisations offer training regarding caring for someone with a particular illness or disability. Training and support available through voluntary organisations, however, is highly variable and dependent on the availability of funding. According to the Carers’ Resource information officer, multiple training courses are available through local colleges, but are not specifically aimed at or designed for carers.

*Voluntary organisations in Bradford*

Traditionally, Bradford has a large and vibrant civil society and strong sense of community (BMDC 2013). In 2013 approximately 1,900 voluntary organisations operated in the area (BMDC 2013).  The Bradford District Compact (BMDC 2015) emphasises the important role of voluntary organisations and encourages partnership working between the statutory and voluntary sectors. Reflecting national trends, however, voluntary organisations in Bradford have experienced many challenges in recent years, including a substantial reduction in revenue, paid staff and volunteers (see Table 5.1).

Table 5.1 Voluntary organisations in Bradford, 2008 and 2013 compared:

|  |  |  |  |
| --- | --- | --- | --- |
| **Voluntary organisations in Bradford** | **2008** | **2013** | **Change since 2008** |
| **Number of organisations**  | 3,400 | 3,600 | Up 6% |
| **Number of activists/ members** | 180,000 | 175,000 | Down 3% |
| **Number of Management Committee Members** | 10,000 | 10,200 | Up 2% |
| **Volunteers** | 33,000 | 31,500 | Down 5% |
| **Number of paid staff** | 6,000(approx 50% full time) | 5,000(approx 60% full time) | Down 20% |
| **Inflation adjusted turnover** | £123 million | £115 million | Down 7% |

*Source: BMDC (2013)*

## 5.3 Carers’ Resource

The CReate project formed part of the work carried out by Carers’ Resource, a Yorkshire-based charity established in 1995 (registered charity No. 1049278). Carers’ Resource has offices based in Skipton, Bradford, and Ripon, and covers an area with approximately 78,000 carers (ONS 2011). The organisation has 75 paid members of staff and approximately 70 volunteers. A board of seven trustees governs the organisation and the Director oversees all services. The yearly turnover for Carers’ Resource is £2.3 million, which, according to Crees et al (2016), makes it a large voluntary organisation. The Director of Carers’ Resource stated in conversation that funding comes from a range of sources, but local authority contracts constitute the largest source of income. Carers’ Resource is a network partner of the Carers Trust, a national umbrella organisation. The Carers Trust aims to raise the profile of carers through their national and local network partners and ensure carers have access to high quality information, advice, and practical support (Carers Trust 2015). Carers’ Resource aim to; deliver tailored information to support carers; offer emotional and practical support; be open to everyone; and work both with and for carers and vulnerable people (Carers’ Resource 2018a). To achieve these aims, services available include: financial, practical and emotional support; planning for the future; hospital admission and discharge support; finding leisure, learning and employment opportunities; developing new hobbies and interests; and forming links with other carers (Carers’ Resource 2018c). Due to disparity in funding, however, services vary depending on location. The Director and founder of Carers’ Resource stated when interviewed that the philosophy of the organisation is, “client-focused…. starting from the carers’ perspective... listening, working at their pace”. Further, she stated:

“So, I hope there’s a philosophy and ethos of open access, welcoming support, support at a pace and in a way that they want it, so we don’t work to a menu where we’ve got to tick boxes, I want us to think about, what is the carer thinking about? What are the issues that present for the carer? Are we understanding where they’re coming from and dealing with their (carers’) problems in their order?”

 (Director, Carers’ Resource)

Carers’ Resource has a long history of supporting carers to combine work and care. According to the Director, Carers’ Resource staff have supported carers in employment since 1997. Initially, they sought to encourage employers in Harrogate to recognise and support carers in the workplace. In 2001, they secured further funding to deliver a carers and employment project in Harrogate for six months. Evidence from this project enabled them to secure funding for a further six months and the Director reported that, ever since, Carers’ Resource have maintained a carers and employment project in Harrogate. When Carers’ Resource opened an additional office in Bradford in 2010, the information team provided some support for carers to combine work and care or return to work. When BIG Lottery announced a call for funding applications, Carers’ Resource Director stated, “we bundled up everything which was good about that work (previous employment support projects), put it into an application to the Big Lottery and we get the contract that’s currently called CReate”.Carers’ Resource defines work-care reconciliation as the ability of carers to combine caring with employment, learning and training, or activities away from their caring role (Carers’ Resource 2012).

## 5.4 Aims of the CReate project

This section outlines the aims of the CReate project, as stated in the Carers’ Resource initial bid for funding. The CReate (Carers’ Resource Employment, Advice and Training) project aimed to: support carers to combine work and care or return to work; support carers to undertake training; and raise awareness of the difficulties that carers face in the workplace (Carers’ Resource 2012). A BIG Lottery grant of £300,000 funded the CReate project for three years (October 2012-2015). Table 5.2 illustrates CReate project services and aims. According to the initial bid for funding, CReate project staff aimed to engage, in particular, with carers from BAME communities, parent carers, and carers in employment (Carers’ Resource 2012). The CReate project manager reported in conversation that the project was designed predominantly based on previous employment support projects run by Carers’ Resource, evaluations of these, and feedback from three focus groups (two with carers and one with partner organisations). Table 5.7 outlines the targets to be met by the project at the end of three years in comparison with CReate project monitoring data regarding the numbers of carers and employers who accessed services. CReate project staff determined target numbers of clients and agreed these with the BIG Lottery Grant Manager.

Table 5.2 CReate project services and aims

|  |  |
| --- | --- |
| **Services** | **Aims of service** |
| **Support**  | * To look at carers’ situations holistically, to identify the specific and multiple barriers that carers face and try to address these barriers.
* To provide tailored information about learning, training and employment opportunities, motivation and emotional support and access to funding and bursaries.
* To provide support throughout the carer’s participation in the project and beyond.
 |
| **Training** | * To build one-to-one relationships to ensure a carer-led service.
* To provide learning and training tailored to carers’ needs to build confidence, self-esteem, and employability skills.
* To promote carer-friendly learning opportunities by working with local learning providers.
 |
| **Development**  | * To work with organisations to raise awareness of issues carers face in the workplace and develop carer-friendly working practices and flexible training opportunities for carers.
* To facilitate work placement and volunteering opportunities for carers and encourage organisations to recognise the benefits of employing carers.
 |

*Source: Carers’ Resource (2012)*

## 5.5 CReate project operational arrangements

This section considers the staff who delivered the project, the services delivered, and partner organisations CReate project staff worked with.

*CReate project staff*

At any one time, three paid personnel delivered the CReate project; one project manager (20 hours a week) and two CReate advisers (one 37 hours a week and one 20 hours a week). In total, eight members of staff delivered CReate services over the three years of funding. The manager remained in post throughout the project. Two volunteers also delivered IT training. Data collection for the study predominantly involved the manager and three members of staff (see Chapter 4). The CReate project manager joined Carers’ Resource in 2001 to work on a carers and employment project in Harrogate. When asked why she applied for the role of CReate project manager, she stated, “I’ve always been keen for people to maximise their potential, particularly carers when it came to work and learning”.The CReate project manager was responsible for overseeing the project, ensuring it met its targets and regularly reporting to the BIG Lottery grant manager. She was also responsible for the work with employers (Carers’ Resource 2012). CReate project adviser 1 had previously worked at Carers’ Resource in a different role but resigned to set up her own business. She also trained as an enterprise coach and benefits adviser and worked in a variety of business start-up advisory roles. She remained in contact with Carers’ Resource and indicated when asked why she applied for the role, that she admired the ethos of the organisation and its track-record of securing funding:

“I think I was always very fond of them as an organisation, I felt like they were a very supportive organisation and a very successful voluntary organisation. Carers’ Resource has always managed to keep a pool of enough money to expand and maintain its services, although not always, sometimes things come to an end”

 (CReate project adviser 1)

CReate project adviser 2 had recently moved to the area when he applied for the role and had a background in law. CReate adviser 3 worked as a primary school teacher for several years before taking up a role writing careers resource material. Following this, she worked as a carer support worker at Carers’ Resource in Harrogate, and then moved into the carers and employment team. At the time of the interview, she had worked for Carers’ Resource for seven years, and had provided work-care reconciliation support for five years. The two volunteers who ran the IT groups were both carers and had backgrounds working in IT. One was retired and stated when interviewed that he wanted to, ‘do something useful’,with his time. The other was a carer seeking to return to work and was delivering the IT groups to build his confidence, following the advice of a CReate project adviser (discussed further in Chapter 6, 6.2).

*CReate project activities*

CReate project staff generated referrals through awareness-raising events, partnership working, and word-of-mouth. The majority of referrals, however, were internal from other Carers’ Resource departments. CReate project staff delivered three main services: support, training, and development.

Support:

CReate project support sessions were one-hour, one-to-one sessions between a carer and CReate adviser. Typically, during the first session a carer attended, the CReate project adviser provided an overview of the support available through the CReate project and determined the carers’ employment and education history. This session was usually also used to establish rapport, consider caring responsibilities, and identify any particular goals or aims. The CReate project adviser and carer completed an action plan at the end of each session that outlined the topics covered and goals to work towards before the next session. It was not compulsory, however, for carers to complete these tasks. The content of one-to-ones varied considerably according to carers’ support needs; some wanted support updating their CV or improving interview skills, whereas others wished to pursue further education or training, or find a local group or activity to have a break from caring. The number of one-to-one sessions that a carer could attend was unlimited, as long as CReate staff felt they were engaging with the project and attempting to progress. Carers could also contact CReate personnel in between sessions via email, telephone, or in person if they had any questions. Chapter 6 provides detailed description of CReate project services in practice.

Table 5.3: CReate project workshops and training delivered:

|  |  |
| --- | --- |
| **Workshops** | **Description** |
| **Positive & Practical**  | A series of 2 hour workshops including:* Aspirations
* Look Good, Feel Good
* Life Coaching
* CV Builder
* Online Job Search Techniques
* Preparing for Interview
 |
| **IT** | * Beginners IT course - 6 weeks
* Improvers IT course - 6 weeks
* IT at home
* Laptop donation scheme
 |
| **Work Club** | Job-search support group run in partnership with the Jobcentre initially |
| **Enterprise Club** | Monthly support group for carers who are self-employed or looking to set up their own business  |
| **First Aid** | 3 hour training session delivered by the Red Cross on the basics of first aid, to assist carers in their caring role  |
| **Money Management** | Four week free course run by Family Action on budgeting, shopping around, planning ahead and dealing with debt  |
| **Exploring Enterprise** | 2 hour workshop for carers considering self-employment |
| **Makaton** | 6 week course on communicating using Makaton to support caring role |
| **Stress Management** | 3 hour workshop on dealing with stress and anxiety  |
| **Working in Retail** | 2 hour introduction for carers considering working in retail  |
| **Working in Care** | 2 hour introduction for carers considering working in the paid care work industry |
| **Introduction to Facebook**  | 2 hour introduction for Facebook, for communication and for self-employment |
| **A Spa at Home** | One-off sessions offering carers a relaxing break  |
| **Pop-Up Shop** | Ran in March 2014 for a week for carers to sell hand-made items  |

Training:

CReate project staff, volunteers, and occasionally staff from partner organisations, ran workshops and training sessions for carers. Workshops were generally free of charge and took place in what CReate project staff referred to as the ‘open space’, a room with one large communal table in Carers’ Resource offices. Workshops were for around six to eight carers. There were several gaps in delivery, however, due to high staff turnover and low referral rates (discussed in Chapters 6 and 8). Table 5.3 outlines the workshops and training sessions delivered during the project. Carers who attended training courses and workshops reported they had often seen them advertised through the Carers’ Resource monthly newsletter, which all carers registered with the organisation received. CReate project staff also encouraged carers attending one-to-one appointments to access workshops.

Development:

The third service delivered by the CReate project was raising awareness with employers of the difficulties carers face combining work and care and working with employers to support carers in the workplace. The CReate project manager was responsible for the work with employers. She attempted to engage with employers using a variety of methods, including: cold calling; emailing; organising networking events; attending local business events; and sending information packs in the post. Support offered to employers included: training on supporting carers in the workplace; advice and support developing a carers’ policy; and support to work towards and implement a carer’s charter mark. The CReate project manager and Carers’ Resource development manager developed the charter mark during the final year of the project. To gain the charter mark, an organisation must complete a set of commitments to support carers in the workplace, including undertaking a health and well-being survey to identify the number of carers in the workforce and implementing a carers’ policy. Observations indicated that, typically, the CReate project manager discussed an employer’s aims regarding supporting carers in the workplace during the initial meeting and outlined the potential ways the CReate project could provide support. Employers then decided what they felt would be most beneficial. Chapter 6, 6.3 examines how CReate project staff delivered services for employers in practice.

Table 5.4: CReate project partnerships by organisation type and role:

|  |  |  |
| --- | --- | --- |
| **Organisation type**  | **Main activities** | **Partnerships** |
| **Government organisations** | Responsible for welfare, pensions and child maintenance policy  | Referral pathwayDistribute information regarding CReate services Representative on the employer’s advisory group  |
| Offers services to people seeking employment and issues financial assistance to those who are not in paid work | Referral pathwayDistribute information regarding CReate services Delivered Work Club for carers in partnership with CReate CReate refer carers to advisor for benefits advice |
| **National organisation** | Provide information and advice to employers and employees on employment law and workplace relations | Working with CReate to develop material regarding supporting carers in the workplace |
| **Local organisations** | Aims to work with companies and individuals to improve their business performance through building networks | Referral pathwayCReate refer carers who are looking to set up their own business.  |
| Programme to help local people start and run small businesses | Referral pathway CReate refers carers who are looking to set up their own businessRepresentative on the employer’s advisory group  |
| Offers courses for adults in the Bradford area. Aim to provide a supportive learning environment | Referral pathway CReate refer carers to specific courses at collegeRepresentative on the employer’s advisory group  |
| Oversees commissioning of services for carers in Bradford District | Commissioner distributes information regarding CReate services Acts as an independent advisor for CReate service development Sits on the CReate employer’s advisory group  |
| Delivers courses to promote a better future through education, enterprise and employment | Referral pathwayCReate refer carers to specific courses |
| Offer training courses and qualifications in areas such as customer service, IT and work skills | Referral pathwayCReate refers carers to specific courses  |
| West Yorkshire social housing provider | Referral pathwayRepresentative on CReate employer’s advisory group |
| **Voluntary Organisations** | Support individuals and organisations with advice and guidance on employment practice, employment law, business development and health and safety | Referral pathwayInformation source regarding employment law and practice for CReateRepresentative on CReate employer’s advisory group.  |
| Deliver business support, advice and training to existing businesses, start-ups, social enterprises and individuals | Referral pathway Distribute information regarding CReate services Representative on employer’s advisory group |

*Partnership Working*

CReate project staff worked in partnership with several organisations to deliver the project. Table 5.4 outlines the primary partnerships, as identified by the CReate project manager using the eco-map (see Chapter 4, Figure 4.1). CReate project partnerships were not mandatory under the BIG Lottery contract (Carers’ Resource, 2012) and most CReate project partnerships were referral pathways with local organisations. The nature of partnerships shifted and changed during the project, and some new partnerships developed, whereas others deteriorated (examined further in Chapter 7, Section 7.3). Eight of the partner organisations outlined in Table 5.4 formed the CReate project’s employer’s advisory group. According to the CReate project manager, the employer’s advisory group met quarterly and was an opportunity for organisations to provide the CReate project with feedback regarding their services and discuss potential further ways they could work in partnership.

## 5.6 CReate project beneficiaries and outcomes

This section presents CReate project monitoring data regarding the characteristics of carers who accessed the project, the services they accessed, and outcomes as reported by CReate project staff. The CReate project was monitored internally and externally. Internal monitoring included collecting quantitative data on the characteristics of beneficiaries who accessed the project, the services they accessed and any resultant outcomes. CReate project staff also kept a case record of all beneficiaries detailing the nature of support needed and provided. Externally, the BIG Lottery Fund grant manager monitored the project yearly and quarterly. A quarterly telephone report on the progress of the project was required, as well as a yearly report including quantitative and qualitative evidence on carers who have accessed the project and their progress regarding employment, education and learning.

CReate project beneficiaries:

Table 5.5 outlines the characteristics of carers who accessed the CReate project, in comparison with carers in Bradford and England, to examine to what extent carers who accessed the project were typical of carers of working age locally and nationally. CReate project monitoring data indicates that a high proportion of carers (67%) who accessed the project were female, in comparison with 58% of carers in Bradford and England. The majority of carers who accessed the project were aged 50-64 (38%), reflecting national trends that those aged 50-64 are most likely to provide care (ONS, 2013b).

Table 5.5: Characteristics of carers who accessed the CReate project in comparison with carers of working age in Bradford and England:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **CReate (%)**n= 332 | **Bradford (%)**(Census, 2011) | **England (%)**(Census, 2011) |
| **Age** | 16-24 | 5 | 8 | 6 |
| 25-34 | 12 | 14 | 9 |
| 35-49 | 33 | 28 | 26 |
| 50-64 | 38 | 33 | 36 |
| **Gender**  | Female | 67 | 58 | 58 |
| Male | 33 | 42 | 42 |
| **Ethnicity**  | White British  | 62 | 70 | 86 |
| Any other white background | 4 | 3 | 3 |
| Pakistani/British Pakistani | 25 | 18 | 2 |
| Bangladeshi/British Bangladeshi | 1 | 2 | 1 |
| Black background | 3 | 1 | 2 |
| Other ethnic background | 5 | 4 | 6 |

*Source: ONS (2011)*

Some carers accessed CReate services although they were aged over 65 as, according to the CReate project manager, if a carer wished to attend training courses such as Beginner’s IT but were not of working age, they were not refused. Similarly, a couple of carers over the age of 65 wished to pursue self-employment for some extra income and also accessed services. Although the majority of carers who accessed the project were White British (62%), Pakistani carers were highly represented. 25% of carers who accessed the project were Pakistani, in comparison with 18% in Bradford and 2% in England. Carers’ Resource staff, however, did not record the number of hours of caring undertaken per week and whether a carer was co-resident. This is a limitation to the data, as these factors affect carers’ ability to combine work and care (Carmichael et al 2010; Heitmueller 2007). Table 5.6 outlines the highest education level, caring relationship and reason for caring, of carers who accessed the CReate project, which have implications for work-care reconciliation (Yeandle et al 2007a).

Carers who accessed the CReate project had high education levels; 77% had two or more A-Levels or the equivalent and only 9% had no formal qualifications. Only 60% of the working age population in Bradford have the equivalent of five good GCSEs and 30% of carers in England and Wales have no formal qualifications (ONS 2011).  The majority (35%) of carers who accessed the project were parent carers caring for a child with a long-term illness or disability.  31% cared for a parent and 23% cared for a partner. The main reasons for caring were disability (25%), learning difficulty (24%), long-term illness (20%), and frailty (14%). The majority (64%) of carers were not in employment when they accessed the project. Chapter 6, 6.2 analyses who benefitted from CReate project services in further detail.

Table 5.6 Highest education level, caring relationships, reason for caring, employment status at start of project and disability of CReate project beneficiaries:

|  |  |  |
| --- | --- | --- |
|  |  | **CReate project (%)** n=332 |
| **Highest education level** | No formal qualifications | 9 |
| 5 GCSEs or equivalent | 14 |
| 2 or more A-Levels or equivalent | 52 |
| Bachelor’s Degree or higher | 25 |
| **Caring relationship** | Parent | 31 |
| Child | 35 |
| Spouse/ Partner | 23 |
| Other relationship  | 9 |
| Former-carer | 2 |
| **Main reason for caring** | Physical disability | 25 |
| Learning disability or difficulty | 24 |
| Dementia | 3 |
| Elderly/ frail | 14 |
| Long -term illness | 20 |
| Sensory Impairment | 3 |
| Mental Health | 8 |
| Drug/ Alcohol misuse | 3 |
| **No. of people cared for**  | 1 | 92 |
| 2 or more | 8 |
| **Consider self to have disability** | Yes | 18 |
| No | 82 |
| **Employment status when accessed project** | Not in employment | 64 |
| Employed | 15 |
| Self-employed | 3 |
| Retired | 6 |
| Not recorded  | 12 |

Services accessed and reported outcomes:

Analysis of quantitative data from CReate project spreadsheets and Carers’ Resource database indicates that in total, 332 individual carers accessed CReate project services. 222 carers received one-to-one support and 200 attended training and workshops. 67 carers accessed both. Figure 5.1 indicates the number of carers who accessed each workshop from data available. According to CReate project monitoring data, staff engaged with 76 employers regarding recognising and supporting carers in the workplace. 42 letters and information packs were sent to employers outlining the business benefits of supporting carers in the workplace and 21 meetings with employers were held to raise awareness of the issues that carers face in the workplace. CReate project staff delivered training for line managers in one organisation and three organisations committed to implementing a carer’s charter mark and carers’ policy. Of the four organisations that engaged with the project, two were public sector organisations, one was a voluntary organisation, and one was in the private sector.

Figure 5.1 Number of carers who accessed workshops by type of workshop:



Of the 222 carers who accessed support services, 18 returned to work, six went into self-employment, 22 began volunteering, 48 went into education or training and nine took up a new activity. CReate project staff defined ‘returning to work’ as being in continuous employment for over 12 weeks, either part-time or full-time. Self-employment referred to setting up a business and commencing trading. Volunteering was defined as undertaking ‘regular’ (at least twice a month) unpaid voluntary work. Further education or training referred to attending courses that ran for at least three weeks and included undertaking CReate project training such as IT skills. A ‘new activity’ was defined as a leisure activity away from caring responsibilities, such as joining a book group or walking group. The outcomes for 119 carers, however, are not known. Either CReate project staff recorded no outcome, or work with the carer was ongoing when funding ended. Consequently, the number of carers who achieved one of the specified outcomes may be significantly higher.

Table 5.7 CReate project services accessed and carer outcomes:

|  |  |
| --- | --- |
|  | **Outcomes**(No. of clients)  |
| **No. of carers who accessed services** | 332 |
| **Services accessed**  |  |
| Support (Carers) | 222 |
| Training (Carers)  | 200 |
| Development (Employers) | 76 |
| **Carer Outcomes**  | No. 222 |
| Returned to work  | 18 |
| Self-employment  | 6 |
| Remained in employment | 2 |
| Volunteering | 22 |
| Further education or training | 48 |
| New activity  | 9 |
| Not known | 119 |

CReate project evaluation data

Table 5.8 outlines the targets CReate project staff agreed to meet and to what extent they met them, according to the CReate project evaluation report (Carers’ Resource 2016). A member of Carers’ Resource development team and a volunteer undertook the evaluation. The evaluation presumed outcomes had been realised if a carer accessed CReate project services. For example, Carers’ Resource staff assumed that carers who accessed ‘support’ services had ‘improved knowledge about how to access information about work and learning opportunities’. Similarly, they considered carers who accessed workshops to ‘have improved skills levels, feel less socially isolated, and have formed peer relationships’. According to CReate project evaluation data, 346 carers accessed the CReate project.

There are discrepancies between CReate project monitoring data and quantitative data collated for the thesis. This is because data for the CReate project evaluation and data for the thesis were collated separately. The CReate project evaluation was completed after the period of data collection. Data was collated for the thesis following the end of BIG Lottery funding, however, before the evaluation was undertaken. As indicated in Chapter 4, CReate project staff recorded monitoring data differently and in different places. Whereas some records were on paper, others were recorded both on paper and electronically. CReate project advisers also recorded data regarding their own clients on separate spreadsheets. Consequently, collating quantitative data was difficult and could have resulted in discrepancies.  Slightly different criteria were also used to examine the data. CReate project staff, the volunteer, and Carers’ Resource development worker, were aiming to demonstrate that they had met BIG Lottery Fund targets, whereas data for the thesis examined the role of the CReate project in promoting carers’ work-care reconciliation more broadly.

Table 5.8 CReate project targets and reported outcomes:

|  |  |  |  |
| --- | --- | --- | --- |
| **Outcome** | **Indicator** | **Target number of carers**  | **Number of carers** (according to CReate project evaluation data) |
| **1. Carers will have improved access to information, advice and support about employment and learning opportunities** | Carers will report that they have improved knowledge about how to access information about work and learning opportunities  | 300 | 346 |
| **2.  Carers will have raised aspirations, improved confidence and skills. Carers will progress into volunteering, further learning or employment** | Carers will have reported that they have raised aspirations, improved confidence and that they have acted upon information, advice and support given  | 180 | 254 |
| **3. Carers will have participated in a range of activities, reducing social isolation and have a life of their own outside their caring role** | Carers will have reported that they have participated in at least three activities, have improved skills levels and feel less socially isolated and have formed peer relationships | 180 | 206 |
| **4. Organisations from a range of stakeholders will be better informed about the employment and learning needs of carers** | Organisations will have reported that they are better informed about carers’ needs  | 5 | 5 |
| Organisations will have reported that they have acted on this and have reviewed their policies and procedures to meet the needs of carers  | 5 | 5 |
| Organisations will have reported that they are identifying and supporting carers in their organisations | 5 | 5 |

*Source: Carers Resource (2016, 2012)*

## 5.7 Summary

The chapter provides an overview of the CReate project, the case study used for empirical research in the thesis. It outlines the context of Bradford the CReate project operated in, including details regarding demographics, the local labour market, carers of working age and carer support and training services. It situates the CReate project within the organisation it operated in, the Carers’ Resource. It highlights the aims of the CReate project and operational arrangements including the staff who delivered the project, activities delivered and partner organisations. It outlines the beneficiaries of CReate project services and the reported outcomes. The following chapter examines the specific role of the CReate project in promoting carers’ work-care reconciliation, and the extent to which it provided a support service which benefitted both carers and employers.

# Chapter 6: The role of the CReate project in promoting carers’ work-care reconciliation

## 6.1 Introduction

Chapter 2 indicated that carers face several barriers to work-care reconciliation and have varied support needs (Vickerstaff et al 2009; Arksey et al 2005; Phillips et al 2002; Yeandle et al 2002). Chapter 3 demonstrated that although some research has considered the role of voluntary organisations in work-care reconciliation (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011a, 2011b; Vickerstaff et al 2009; Yeandle and Starr 2007; Formby and Yeandle 2005; Arksey 2003), the specific role voluntary organisations can play, remains under-researched. Chapters 2 and 3 also indicated that further longitudinal research into the role of voluntary organisations would be beneficial. The chapter seeks to address these gaps in the literature and considers the main question:

* What role can voluntary organisations play in promoting carers’ work-care reconciliation?

It also examines these sub-questions through the case study of the CReate project:

* To what extent did the CReate project provide a support service from which both carers and employers benefitted?
* What were the characteristics of carers who accessed the project?
* What impact did carers’ involvement have on their decisions and behaviour regarding work and care?
* How were the design and implementation of the CReate project, and its outcomes, affected by the funding and public policy context within which it operated?

To answer these questions, the chapter examines the design, implementation, and impact of the CReate project. From an ethic of care perspective, it is important to consider all stages of the caring process (Tronto 2013; Tronto and Fisher 1990). The chapter provides in-depth case studies, describing how, and to what extent, CReate project staff promoted carers’ work-care reconciliation in practice. It examines the role of the CReate project in ‘delivering person-centred support’ and ‘creating carer-friendly workplaces’ (outlined in Chapter 2). The chapter considers the impact of the project for carers and employers, and analyses who benefitted, (or did not) from the project, and why. The qualitative longitudinal research method used here is particularly effective for examining policy implementation in practice (Corden and Millar 2007). An in-depth case study enabled the context to be considered, and a holistic view of work-care reconciliation support in practice to be developed (Yin 2011).

The chapter draws on data collected from ten carers tracked through the project and beyond for up to two years[[36]](#footnote-36), and interviews with other participating carers and employers. Interviews with CReate project staff, CReate project monitoring data, and documentary analysis of CReate project client records, project materials, and evaluation reports, also inform analysis. The chapter is organised as follows. Section 6.2 examines evidence regarding the design, implementation, and impact, of CReate project services for carers in practice. It considers the extent that CReate project services can be conceptualised as, ‘delivering person-centred support’, and analyses the impact of these services for carers. Section 6.3 describes how CReate project services for employers were implemented in practice, examines to what extent services can be interpreted as, ‘creating carer-friendly workplaces’, and analyses the extent carer-friendly workplaces were established. Section 6.4 summarises the main arguments of the chapter.

## 6.2 Delivering person-centred support

This section examines to what extent a person-centred approach to service delivery was present in the design and implementation of CReate project services. With a person-centred approach: beneficiaries are viewed as individuals and participants in services; a holistic approach to service delivery is adopted; and it is recognised that all carers have unique histories and social identities which affect their support needs and decision-making[[37]](#footnote-37) (WHO 2016; Beresford 2011; Brooker 2007; Dowling et al 2006; DH 2005; Parley 2001; Stalker and Campbell 1998). Accessing person-centred support should ensure carers have the necessary information and support to make decisions regarding work and care.

*A person-centred approach in the design of CReate project support services for carers*

Evidence from documentary analysis of the Carers’ Resource (2012) bid for funding and interviews with CReate project staff, indicate that the characteristics of a person-centred approach were apparent within the design of the project. The language used in Carers’ Resource initial bid for funding (outlined in full in Chapter 5, Table 5.3), reflects a person-centred approach. Carers’ Resource use phrases such as ‘to look at carers’ situations holistically’ and ‘to provide tailored information’, which suggest they aimed to consider carers as individuals and take a holistic approach to service delivery (Carers’ Resource 2012 p.13). The bid for funding states that the CReate project aimed to equip carers with the relevant knowledge and skills to make informed decisions regarding work-care reconciliation and refers to the participation of carers (Carers’ Resource 2012). Accounts from CReate project staff regarding how they aimed to implement services also reflect a person-centred approach:

“I suppose we all have our different ways of working, and the way that I like to engage with people is to make them feel safe and comfortable, not have any pressure, and work in an environment of honesty. I certainly don’t want to set anybody up to fail, it’s about giving people encouragement because my passion is about helping people to achieve their potential. So, it’s getting carers to remember and recognise what they’re good at, and no matter what it might be and how small it might seem to them, to just make them realise”.

 (CReate project manager)

“I think one of the things that we do, that they do try and preserve here, is that you work with clients according to their needs rather than a particular formula”.

 (CReate project adviser 1)

Another member of staff specifically referred to employing a person-centred approach, which they researched on the recommendation of a former colleague at Carers’ Resource:

“I think one has to work with their natural strengths and interactions, so I do believe that I have developed my own approach, it has been organic, it has taken a while, but it’s based upon the person-centred approach. One of the aspects of the person-centred approach is essentially being very honest with the person sitting opposite you, using empathy from the perspective of where a person has come from, and being able to engage with people on various levels. It does allow a person to try and create a bespoke, tailored, and appropriate, service for individuals”.

 (CReate project adviser 2)

The CReate project manager stated in conversation that when recruiting new members of staff, the principal attributes she and Carers’ Resource managers looked for were: an understanding of the issues that carers of working age face; expertise in employment support; local labour market knowledge; and competency in South Asian languages. Carers’ Resource staff recognised that carers have different social identities and histories and endeavoured to employ staff with appropriate skills. Evidence indicates that Carers’ Resource and CReate project staff aimed to deliver services in line with a person-centred approach.

A *person-centred approach in the implementation of CReate project support services for carer*

In practice, too, the support services observed during the research adopted the principles of a person-centred approach. The case study of Pat (outlined in Box 6.1), one of the participants followed through the project, demonstrates this[[38]](#footnote-38).

Box 6.1 Case study: Pat

Pat, aged 50, cares for her son with autism. She had previously also cared for her mother who died five years ago. Pat lives with her husband and has five children. Three were grown up and had moved out of her home. Pat has a degree in psychology and had been out of the labour market for ten years. Previously, she worked in a variety of project worker and project management roles supporting vulnerable people.

Pat initially accessed the CReate project 18 months prior to my initial contact with her. She heard about the project by attending a health and well-being fair run by the local authority and attended three one-to-one support sessions with a CReate adviser. She stated in the initial interview, however, that as her son’s behaviour became more difficult to manage, she felt unable to engage fully with the project, or return to work, at the time. Pat re-contacted the CReate project after her son received a place at a specialist secondary school. She arranged an appointment with an adviser for the following week.

The adviser she had previously seen had since left the organisation. When asked what she hoped to gain from accessing the CReate project during the first interview, Pat emphasised the importance of having something for herself and having some disposable income:

 “I just need to get out the house. I just need to do something different than just sitting here getting mouldy, and of course, the money, I hate, I mean I did get family tax credits and Carers’ Allowance, which went a little way, but you never have a great deal, and they’re (two sons) older now, they want to do loads of different things, and he (son and care recipient) wants to go on holiday and all these things cost money”.

Contemporaneous observation of Pat attending her first support session with a CReate adviser:

*It is the day of Pat’s first appointment. The CReate adviser greets her warmly in the reception waiting area and invites her into one of the small private rooms. She offers Pat a drink, who accepts a cup of tea. They sit at a small table opposite each other. Pat seems nervous.*

*The CReate adviser introduces herself and briefly outlines the services and support available through the CReate project. She asks Pat about her caring responsibilities and previous employment history. Pat speaks openly about her son and the struggle she has been through to get him into a suitable school. She outlines her most recent employment history, with encouragement from the adviser, and shares a copy of her CV she has brought with her. The CReate adviser states she is impressed with Pat’s wealth of experience. Pat seems unsure how to respond.*

*The adviser asks Pat, “What would you find helpful from the CReate project?”*

*Pat states she has lost confidence being out of the labour market for a significant time and is unsure of the employment direction she wishes to pursue. She feels, however, that she would like to utilise the skills and expertise in a paid role that she has developed caring for her son. The adviser further probes, “What would your dream job be?”*

*Without hesitation, Pat states “a support worker role”. She elaborates; she has previously had several support worker roles and feels they are often flexible. On reflection, however, Pat confides she has always wanted to be a mental health nurse and had a place on the required course but did not complete it as her caring responsibilities became more demanding. The CReate adviser suggests they spend a month searching for and identifying appropriate support worker roles and investigating the possibility of completing her mental health nursing degree, including local training opportunities and potential costs.  Pat readily agrees. She states hesitantly that she will have to search for jobs that are term-time only and 30 hours a week, to accommodate her caring responsibilities. The adviser proposes they search for roles which mention they are ‘flexible’, but also states that employers can often be more flexible than advertised, for the right candidate.*

*The CReate adviser asks Pat how confident she feels searching for jobs online, updating her CV, and writing job applications. Pat states she is happy using computers and online search engines. The previous CReate adviser had updated her CV, but she did not feel confident writing applications. The CReate adviser suggests specific websites to search, which Pat makes a note of, and assures she will provide support with writing applications when required.*

*Pat divulges she is concerned about her age. The adviser reassures her that with her wealth of experience, age is a positive attribute. She further advises Pat to emphasise in her CV that she was not ‘unemployed’ for the past few years, but caring for her son, and learnt valuable skills through doing so. For the remainder of the session they develop an action plan for the coming weeks. Pat becomes more at ease and seems enthusiastic in pursuing her goals. Pat is to update her CV, search for support worker roles, and consider the feasibility of pursuing mental health nursing. The CReate adviser is to identify suitable jobs and training opportunities.*

*They agree that by the next session they will have found at least one position to apply for, so Pat can practice writing job applications. The CReate adviser records these intentions in writing, both sign the bottom of the page, and the adviser photocopies it so they both have a copy. At the end of the session, they agree to meet in two weeks’ time, as well as to keep in contact via email, to share relevant job opportunities. Pat thanks the adviser, the adviser expresses she was glad to meet her, and sees her out to reception.*

During the second appointment, they edited Pat’s job application and the adviser made suggestions regarding phrasing and technical language, until they were both satisfied it was ready for submission. Her application was successful, and she was invited for interview. The CReate adviser suggested a mock interview would be beneficial, as Pat had been out of the labour market for several years. Pat agreed, and during the third session the adviser asked her practice interview questions and gave her tips and advice on interview techniques. Above all, the CReate adviser provided encouragement.

Following the advice of the CReate adviser, Pat indicated at the beginning of the interview that she was only able to work 30 hours a week and term-time hours. Pat reported in the follow-up interview that the line manager agreed to flexible working hours and term-time only and had appointed a second part-time employee to share the role.

Several aspects of a person-centred approach were apparent within the case study example. The CReate project adviser commenced the first appointment by enquiring about Pat’s caring responsibilities, employment history, and employment wishes. The adviser acknowledged that all carers are unique and have individual circumstances, histories, and preferences that affect their support needs, and decision-making, regarding work and care. Furthermore, the CReate adviser recognised that care is a relationship, which she considered in service delivery. Nearly all observed support sessions began in a similar manner. The CReate adviser regarded Pat as a participant in services and delivered services in collaboration with Pat rather than *to* Pat. Pat and the adviser, for example, worked together to develop the application form, and formulated the action plan in partnership; both agreed to complete specified actions and play an active role in service delivery. CReate advisers developed action plans in collaboration at the end of every one-to-one support session observed. Several carers tracked through the project, and interviewed, felt they were participants in service delivery:

“I think that they cater for your needs really, they listen to you and see what you feel you need”.

 (Clare)

“…I think (adviser) was very good in terms of the fact that she allowed me to set the agenda, and she offered the sort of support that I needed. Obviously, it was very non-directive, the problems and the solutions lay within me and I just needed help drawing them out and making them into something that I could do something about. I think in a very short space of time I did that but it’s sometimes the sort of thing that you can’t do on your own, for whatever reason”.

 (Lawrence)

“I thought it was a very, very good service and I can remember saying to someone ‘it’s like a lifesaver’, you know it did feel like a lifeline. Maybe I’d got a bit isolated as well with getting quite down, sort of depressed, and just taking that first step of coming to someone and (adviser) was so lovely and I just felt as if I was able to tell her exactly what I wanted, that I needed to get a job but I was worried I wasn’t up to it at the moment. And having someone who was calm and able to take you through things, I felt supported, I thought, there is someone on my side actually. And then (adviser) had really useful information and I used to come away feeling quite energized. I’d recommend it to anyone”.

 (Carer B)

These accounts indicate that these carers participated in service delivery, and that CReate project advisers endeavoured to ensure they had the relevant information required to pursue their work-care reconciliation goals, in line with a person-centred approach. CReate project staff also delivered training and workshops in accordance with the principles of a person-centred approach. A case study of one of the Beginner’s IT Groups[[39]](#footnote-39), outlined in Box 6.2 demonstrates this. The group described was a six-week course led by a volunteer, who was also a carer, had a background of working in IT, and had previously accessed the CReate project. Eight carers enrolled on the course and each session lasted two hours. The volunteer developed the course structure and materials and agreed them with the CReate project manager.

Box 6.2 Case Study: Beginners IT Group

Contemporaneous observation of a Beginners IT group:

*It is the first session. The large meeting room has one large table in the middle and laptops set up around it. Wires run in lines to the nearest sockets. The room is light and airy, and a table in the corner is laden with tea, coffee, and biscuits.*

*The volunteer hurriedly ensures all is in place and organises the course materials. Carers gradually amble into the room uncertainly. The volunteer greets and welcomes them enthusiastically and invites people to choose a place to sit, and to help themselves to tea and coffee. The carers exchange small smiles.*

*After five minutes, the volunteer shuts the door. Only six carers are present. The volunteer introduces himself and explains his background in IT, how he came to volunteer with CReate, and emphasises that he is first and foremost, a carer for his wife. He asks the group to introduce themselves. They do so one-by-one, some reluctantly.*

*The volunteer lays some ground rules for the course. He states that, ideally, people attend all sessions, or as many as possible, as they lead on from each other, and it works best when people get to know each other. He clarifies, however, that he understands this may not be possible, given the often-unpredictable nature of caring and illness. He emphasises that the course is about ‘having a go’, and that there is no pressure to attain a certain level. He highlights that previous courses have been as much social as they are about learning IT and aims for this one to be the same. He openly asks the group what experience, if any, people have had with computers.*

*There is a pause. One woman offers that her children have tried to show her the basics, but she found it difficult to digest, so wanted to learn for herself. Others have no experience with computers.*

*When discussing with the group the reasons for attending the course and what they hope to gain from it, a couple state they want specifically to be able to email and use Skype to keep in touch with relatives. One woman wishes to learn IT skills for her job, which were not required previously, but now are. Most emphasise they want to learn something new and have something for themselves, away from their caring activities. The volunteer hands round booklets of the material covered this week.* He stated when interviewed:

“Everyone goes ‘I can’t remember the terminology’, but it’s in the notes, so they can always get back to it. They’ve got something with which they can do the exercises again and refresh their memory”.

*During this first session, the volunteer covers the basics such as turning the computer on and safely shutting it down, as well as opening and searching for files. He explains things verbally, refers to the handouts, and uses flipchart paper to draw diagrams of the processes he describes. He asks the group to search for a file that is on all the laptops. He responds to questions and goes around individually to check everyone has understood and correctly completed the task. Carers encourage each other.*

*One woman is unsure she can find it, the woman next to her states, ‘course you can’. One carer exclaims, ‘ah, it’s like Sherlock Holmes with the spyglass’. This resonates with the group. There is a ten-minute coffee break in the middle of the session. The volunteer leaves the room, and the carers make small talk with each other.*

*Six weeks later, it is the final session. As I enter the room, carers are chatting happily amongst themselves. The volunteer interrupts to start the class. He outlines that in this session, they will focus on setting up an email account, and how to send and receive emails. Several carers requested this in a previous session. The volunteer suggests they use Hotmail, as he felt it was a relatively straightforward process to set up an account, and it would be easiest for everyone to use the same provider. Once they have set up an email account with the support of the volunteer, he invites them to swap email addresses. He then suggests they email the person sitting next to them, to practise sending and receiving emails. They help each other.*

The volunteer in the case study example viewed carers as individuals and participants in services. He recognised that carers were at different levels in terms of ability and required some individual support. He also encouraged the participation of carers, and stated when interviewed, ‘…and I want it to come from them (carers) as much as possible, so, people can support each other’.Observations over the six weeks indicated that carers increasingly participated as they felt more at ease with each other. The volunteer also adopted a holistic approach to service delivery, as he made clear he understood if carers were unable to attend every week and established a welcoming environment in which carers felt able to participate[[40]](#footnote-40).

Implementation of CReate project services reflected several components of a person-centred approach, including: treating carers as individuals; adopting a holistic approach to service delivery; and viewing carers as participants in services. This echoes some previous research, which suggests voluntary organisations are often effective at providing tailored employment support for carers (Wigfield and Marangozov 2014; Vickerstaff et al 2009). A person-centred approach, however, goes beyond ‘tailored’ support, and includes the participation of carers in services (Dowling et al 2006). CReate project staff promoted carers’ work-care reconciliation by delivering person-centred support.

*Impact of CReate project person-centred support services for carers*

This section examines the impact of CReate project (person-centred) support for carers. It examines quantitative CReate project monitoring data regarding the characteristics of carers who accessed the project, the outcomes of carers, and characteristics of carers who achieved outcomes. This section then explores qualitative data regarding the impact of the project for the ten carers tracked through the project, and to what extent these carers achieved their aims regarding work and care, and why. From an ethic of care perspective, it is important to examine who benefitted from services in practice, and why (Williams 2002). Some carers were more likely to access CReate project support than others were. As outlined in Chapter 5 (see Tables 5.5 and 5.6), most carers who accessed the CReate project were women, White British, parent carers, aged 50 to 64, and those who had higher levels of education (at least two A-levels or the equivalent). Quantitative monitoring data indicates that CReate project staff engaged with some of their target groups of carers (BAME carers and parent carers), but not others (carers in employment). 25% of carers who accessed the project were Pakistani, compared with 18% of carers of working age in Bradford (ONS 2011). Only 15% of carers who accessed the project, however, were in employment.

These findings largely echo evidence from previous programmes for carers delivered by voluntary organisations. Voluntary sector staff were often effective at engaging with BAME carers and parent carers when they were a target group (Buckner and Yeandle 2011; Buse and Wigfield 2011; Yeandle et al 2011; Yeandle and Formby 2005). A high proportion of BAME carers accessed the Caring with Confidence programme(Buckner and Yeandle 2011), and in some areas, over 50% of carers who accessed National Demonstrator Sitehealth checks were of BAME heritage (Buse and Wigfield 2011). Staff who delivered the Demonstrator Sites programme felt they had been effective at engaging with parent carers (Buse and Wigfield 2011). Women were also more likely to access ACE National projects and Caring with Confidence (CwC) training[[41]](#footnote-41) (Buckner and Yeandle 2011; Yeandle and Formby 2005).

Quantitative monitoring data indicates that CReate project staff engaged with a high proportion of parent carers and BAME carers, however, only engaged with a low number of carers in employment[[42]](#footnote-42). According to Yeandle et al (2007d), however, carers in employment are often less likely to access services than other carers, and Arksey et al (2005) identified restrictive opening hours as a limitation of voluntary organisation support for carers. All CReate project services ran during working hours (9-5), which the CReate project manager acknowledged made it difficult for those in full-time employment to attend. Carers in employment were also not likely to access organisations CReate project staff engaged with to generate referrals. Observations indicated that CReate project staff undertook outreach work, in particular, with the Jobcentre, lunchtime parent carer groups, and Asian women’s groups, that ran during the day.

CReate project staff exceeded their targets in terms of the numbers of carers who accessed services (see Chapter 5, Table 5.8). CReate project staff aimed to engage with 300 carers, and 332 accessed the project[[43]](#footnote-43). Of those who accessed CReate project support services[[44]](#footnote-44), 24 (11%) went into employment or self-employment, 22 (10%) began volunteering, 48 (22%) went into further education or training, and nine (4%) took up a new activity[[45]](#footnote-45). As stated in Chapter 5, the numbers of carers who achieved outcomes after accessing the CReate project may be significantly higher, but outcomes are not known, and were not recorded for many carers (54%). The number of carers CReate project staff supported to remain in employment may also be higher than reported, as observations indicated that CReate project advisers often provided ‘ad hoc’ support for carers in employment, which they did not record within monitoring data. For example, CReate project adviser 1 provided support over the phone and via email for one carer who was unsure how to approach their line manager to request flexible working. The CReate adviser supported them to write a formal request letter and provided a letter of support from Carers’ Resource. CReate project staff, however, did not record details of these interactions within monitoring data, as the carer had not had a formal appointment with Carers’ Resource staff.

Quantitative monitoring data indicates, however, that some carers were more likely to achieve an outcome after accessing the CReate project than others. Table 6.2 indicates the outcomes of carers who accessed support services by age, gender, ethnicity and employment status when they accessed the project. Only 11% of Pakistani/ British Pakistani carers achieved an outcome, in comparison with 42% of White British carers who accessed the project. A higher proportion of women achieved an outcome than men, and those aged 50-64 were more likely to achieve an outcome than other ages. Those not in employment were also much more likely to achieve an outcome than those in employment. Carers from the CReate project’s target groups were less likely to achieve an outcome[[46]](#footnote-46).

Table 6.2 CReate project carer outcomes, by selected carer characteristics

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Outcome** | **Returned to work** | **Entered self-employ-ment** | **Remained in employ-ment** | **Volun-teering** | **Education or training** | **New Activity** | **% of category that achieved an outcome**  |
| **Charact-eristics of carer** |  |  |  |  |  |  |  |
| **Gender** |  |  |  |  |  |  |  |
| Female  | 10 | 4 | 2 | 19 | 40 | 6 | 36  |
| Male  | 8 | 2 | 0 | 3 | 8 | 3 | 22 |
| **Age** |  |  |  |  |  |  |  |
| 16-24 | 3 | 0 | 0 | 0 | 3 | 0 | 35 |
| 25-49 | 9 | 3 | 1 | 12 | 18 | 3 | 31 |
| 50-64 | 6 | 3 | 1 | 9 | 23 | 5 | 47 |
| 65+ | 0 | 0 | 0 | 1 | 4 | 1 | 15 |
| **Ethnicity** |  |  |  |  |  |  |  |
| White British | 15 | 6 | 2 | 17 | 40 | 7 | 42 |
| Other white background | 1 | 0 | 0 | 0 | 3 | 0 | 30 |
| Pakistani/ British Pakistani | 2 | 0 | 0 | 4 | 4 | 1 | 11 |
| Black back-ground | 0 | 0 | 0 | 1 | 0 | 0 | 10 |
| Other ethnic back-ground | 0 | 0 | 0 | 0 | 1 | 1 | 12 |
| **Employ-ment status when accessed project** |  |  |  |  |  |  |  |
| Not in employ-ment | 18 | 6 | - | 22 | 48 | 8 | 48 |
| Employed | 0 | 0 | 2 | 0 | 0 | 0 | 4 |
| Self-employed  | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Quantitative evidence indicates that the CReate project was effective at engaging with two of its target groups of carers (parent carers and BAME carers) but did not engage with as many carers in employment as anticipated. The CReate project did, however, exceed its targets in terms of the numbers of carers who accessed services. The proportion of carers who achieved an ‘outcome’ could also be higher than stated, due to incomplete monitoring data. Women and those who identified as White British were most likely to achieve outcomes. Quantitative monitoring data suggests that some groups of carers benefitted more than others from CReate project services.

This section examines qualitative evidence regarding carers’ experiences of CReate project services, their reported outcomes, and to what extent carers tracked through the project achieved their own personal aims regarding work and care, and why. Evidence from interviews indicates that carers were highly satisfied with CReate project services, and all carers tracked through the project and interviewed, had positive experiences of the project. Nearly all carers interviewed reported improved confidence after accessing CReate project services:

“I mean the big thing for me was, as crazy as it seems, was confidence-boosting, having somebody behind you saying ‘no, apply for that one’, hint. I would not be able to stand up in front of people at all and talk unless it was for (adviser) who mentored me through that dark patch, as I was just not sure. She pushed me and that was nice, she pushed me slightly outside of my comfort zone and it paid off. I’ve succeeded because of that, so that’s testimony to CReate”.                      (Frank)

“…And I know I wouldn’t have this job without her because that day when I came and she did that interview with me and went through all the questions and prompted me, I wouldn’t have thought of saying half that stuff. I could not have done it without (CReate adviser). She really boosted my confidence. All through the interview, I was thinking of the advice she had given me”.

                                                                                                                    (Pat)

Lawrence stated during the initial interview:

“I think that some of the issues that we’re dealing with in the one-to-ones are actually very important to me because we were talking about comfort zones in the first session and my comfort zones shrunk and I think that I need to gain confidence again. I think that I’m quite confident in who I am and in sort of a narrow confine and I’m confident intellectually and in challenging things but I think that I’ve lost that connection with moving around in wider circles really”.

And in the follow-up interview:

“I mean there were some things, particularly the issues about the narrowing of my boundaries, which were of grave concern to me really and to some degree, little by little, I’ve addressed that. I mean I think there are still some issues which I need to sort out but we are getting there. I’m certainly moving round a lot more and doing a lot more and of course that takes on its own momentum and what seemed like issues evaporated”.

                                                                                                    (Lawrence)

In discussion of their experiences of the IT sessions observed, most carers felt more confident using computers. One carer stated, ‘*I’m not so scared anymore’*. Another carer stated in a follow-up interview:

“….Absolutely fabulous, they’ve helped build my confidence up, if I go back to work in a hospital or anything like that you have to learn the computer so now at least I’ll have the confidence to go on it. Whereas before I would not go anywhere near it. It has taught me a lot really, I mean ok, sometimes I might get it wrong, but somebody is willing to show you then because at least you have tried.  I sent an email today with their help, and (carer) next to me opened it, you can be in touch”.

                                                                                                               (Carol)

Improved confidence was the principal outcome mentioned by carers tracked through the project, and was viewed as essential by project staff, for carers to pursue their goals regarding employment, work, or learning. These findings reflect some previous research findings regarding the role of voluntary organisations in promoting carers’ work-care reconciliation. Project workers who delivered the ACE National project reported carers’ growth in confidence and self-esteem as the ‘most visible impact of project participation’ (Formby and Yeandle 2005, p.15).

Delivering services in line with a person-centred approach was important for building the confidence of carers who accessed the CReate project, and tailoring services to the specific needs of individual carers ensured that support was appropriate. Pat, for example, required support with interview techniques, whereas Lawrence wished to build confidence to undertake social activities and travel outside the area he lived in. Taking a holistic approach (central to a person-centred approach) was also important, and evidence from these interviews indicates that CReate project staff recognised that carers, and especially those who have been out of the labour market for some time, have often lost confidence (Carers UK et al 2012). CReate project staff did not deliver services solely to obtain an outcome, such as gaining employment, but recognised that carers often need more holistic support. The importance of tailored support is also emphasised by Formby and Yeandle (2005) and Wigfield and Marangozov (2014).

One of the other principal outcomes of the CReate project, reported by carers when interviewed, was increased motivation to pursue their goals around work and care:

 “(Adviser) is good at motivating, she’s that inspiration, you can go and talk to her and she’ll pull you through. I don’t think she realises how inspiring she is, but to me she is, she motivates me to actually go and get things done”.

 (Clare)

“I do get an awful lot of motivation out of it (CReate project), I suppose it makes me sound like I’m a bit lazy but I have to say that I do things and then I think I put other things aside that I don’t really want to do quite so much and I know the deadline is coming up for the next thing, for the next meeting, so it does motivate me to do things”.

   (Barbara)

Setting small, achievable goals motivated these carers to pursue their aims. Carers tracked through the project were highly positive regarding their experience of CReate project one-to-one support services. Similarly, evidence regarding carers’ experiences of training and workshops, indicated they highly valued the opportunity to meet other carers, learn a new skill, and have a break from caring. Documentary analysis of CReate project feedback forms (n=84) completed by carers at the end of training sessions and workshops, indicated that the majority (96%) of carers felt training met their expectations, and that they would recommend the training to a friend[[47]](#footnote-47). Comments from the Exploring Enterprise workshop included; ‘*positive and encouraging’* and *‘I enjoyed the interaction between people and the information given’.* The accessibility and clear presentation of information was also highly valued. Carers following the Introduction to Working in Retail workshop stated, *‘enjoyed the interaction and team-building’,* and *‘enjoyed learning how to be more confident’*. In relation to the Managing Stress session, one carer stated, ‘*enjoyed knowing I’m not alone’.* This reflects some findings in previous research which indicates that carers highly value the opportunity to mix with other carers (Buckner and Yeandle 2011; Formby and Yeandle 2005).

Participants in one CReate project IT group felt they would like to continue to meet after the course ended and decided to meet socially for a coffee every week in a local cafe. A few carers, however, felt that training sessions they attended ‘were not for them’. One carer, who attended the Managing Stress workshop, stated in conversation that she did not feel comfortable talking about her caring responsibilities openly with others. Conversation with the discussion group (see Chapter 4, Section 4.5) also indicated that carers often did not have the confidence to attend groups initially. All carers in the discussion group stated they felt more comfortable accessing group workshops and training after engaging with a CReate project adviser in a one-to-one capacity. Carers tracked through the project and those who attended workshops reported several benefits of accessing CReate project services, including: increased confidence; meeting other carers; increased motivation to pursue goals; improved knowledge, particularly regarding self-employment; and ‘knowing someone was there for them’.

Of the ten carers tracked longitudinally through the project and beyond, four returned to work, one remained in employment, two set up in self-employment and commenced trading, one set up in self-employment but had not commenced trading, and three pursued volunteering and activities outside of caring[[48]](#footnote-48). Table 6.3 outlines the aims of carers tracked through the project when they initially accessed it, the services they accessed, and the reported impact of the project.

Table 6.3 Aims, services accessed and reported outcomes of carers tracked through the project:

|  |  |  |  |
| --- | --- | --- | --- |
| **Carer**  | **Aims when accessed project**  | **Services accessed**  | **Carer reported outcomes\*** |
| **Pat** | To return to work  | Three one-to-one support sessions | Returned to work Reported improved confidence and increased knowledge regarding applying for jobs and improved interview skills  |
| **Clare** | Remain in employmentLong-term goal to set up in self-employment  | Three one-to-one support sessions | Remained in employment and was working towards setting up in self-employment. Work with CReate project was ongoing when funding came to an end. Reported increased motivation to pursue goals and was supported (successfully) to apply for a Carer’s Small Grant to undertake training.  |
| **Rachel** | To return to work or pursue education or training  | Three one-to-one support sessions | Remained out of work. Pursued other activities; joined social groups |
| **Lawrence** | To set up in self-employment  | Two one-to-one support sessions Enterprise Club  | Pursued volunteering and other activities Reported improved confidence and expanded comfort zones  |
| **Natasha** | To set up in self-employment | Three one-to-one support sessions Enterprise Club | Set up in self-employment and commenced trading Reported improved confidence and increased knowledge regarding self-employment  |
| **Louise** | To set up in self-employment | Two one-to-one support sessions | Set up in self-employment and commenced trading Reported increased knowledge regarding self-employment  |
| **Carol**  | To return to work | Four one-to-one support sessions Beginner’s IT group Managing Stress Workshop | Returned to work Reported improved confidence, expanded comfort zones, increased skills in IT and greater knowledge regarding searching for and applying for jobs |
| **Barbara** | To set up in self-employment | Four one-to-one appointments Enterprise Club | Set up in self-employment but had not commenced trading. Reported improved confidence and increased knowledge regarding self-employment.  |
| **Frank** | Return to work  | Six one-to-one appointments  | Pursued volunteering/ other activities Reported improved confidence |
| **James** | Return to work  | Four one-to-one appointments  | Returned to work Reported improved confidence  |

\*Carers’ reported outcomes were based on follow-up interviews with carers

All had made some progress towards employment, education or training after nine months, although not all had achieved their aims when project funding ended. Several factors affected the ability of carers to pursue their goals, including: the availability of formal care services; carers’ own health; and the availability of good quality, flexible, jobs in the area. Pat, for example, was offered the job she applied for as a support worker after accessing three one-to-one appointments with a CReate adviser. After nine months, she reported via email that she was happy with her new role, and particularly valued the financial security it brought. Although she stated that accessing the CReate project had built her confidence and developed her interview skills, Pat had also secured a suitable school place for her son and negotiated term-time working, which were also important factors in enabling her to return to work. According to Stiell et al (2006), parent carers often face difficulty negotiating suitable flexible working hours. Pat was also highly qualified for the role; she had significant experience within support work and a bachelor’s degree. She reported, when interviewed, that although she had had ‘some family issues to deal with’, she received counselling for these, and did not feel they were a barrier to returning to work.

Although a CReate project adviser provided Pat with practical and emotional support, which she highly valued, she also had appropriate care for her son, a flexible job, good qualifications and work experience, and no discernible health concerns which, combined, enabled her to combine work and care. Pat, however, stated in a follow-up email that she was having difficulty with her employer as her son had been hospitalised several times and she had had to take time off, sometimes at short notice, to attend appointments. She reported her line manager was not understanding and felt that carers’ leave would be helpful for her to combine work and care.

For Natasha, who cares for her disabled uncle, appropriate formal care services alongside CReate project support were important for enabling her to pursue self-employment. Natasha stated during her initial appointment with a CReate adviser that she wished to set up a cleaning business. She had previously worked for a cleaning company but stated she wished to set up on her own, have more control over her hours and come off benefits. She attended three one-to-one appointments, over nine months, and attended the Enterprise Club for carers pursuing self-employment, which ran monthly. She received practical and emotional support from a CReate project adviser around setting up the cleaning business. Three months after her first appointment, she commenced trading. After nine months, she reported via email that she had a core group of clients which provided her with sufficient income, although she would have ideally liked a couple more clients. Natasha, however, did not have intensive caring responsibilities; she reported she cared for around ten hours a week, but that she now mainly carried out administrative tasks as her uncle had recently moved into a care home. Although the CReate project supported Natasha to set up her business, her uncle received formal care services which also enabled her to pursue her goals regarding self-employment.

A CReate project adviser also supported Louise to set up in self-employment. She worked with a CReate adviser to develop and implement a business plan. Louise commenced trading and reported after nine months that business was ‘booming’. She stated it provided her with sufficient income, and that she was ‘really enjoying it’. According to Louise, self-employment also gave her the control and flexibility to care for her mum, who she cared for at a distance. Self-employment enabled her to visit for two or three weeks at a time, several times a year. Alongside CReate project support, Louise also received the New Enterprise Allowance (NEA)[[49]](#footnote-49), administered by the Jobcentre. She reported this enabled her to cover the initial costs of setting up the business and ensured she did not face a ‘cliff edge’ when she came off benefits. She also indicated she had a good network of friends who provided emotional support.

Although the CReate project built these carers’ confidence to pursue their goals and provided practical and emotional support to return to work or set up in self-employment, the extent of caring responsibilities, availability of adequate formal care services or school places, support from friends, statutory financial support, and the availability of good quality flexible jobs, were also important. Previous research also identifies these factors as important for enabling carers to combine work and care (Hamblin and Hoff 2012; Vickerstaff et al 2009; Stiell et al 2006; Yeandle et al 2007b; Arksey et al 2005). A lack of good quality, flexible jobs, carers’ own health, intensive caring responsibilities, and CReate project funding ending, prevented some carers who accessed the project from realising their goals. Although four carers tracked through the project returned to work, this was not always within their preferred line of employment. James, for example, took up a position as an information officer with a voluntary organisation, although he had previously been a University lecturer. He found it difficult to return to academia after a four-year gap in his career due to caring. He stated when interviewed:

“I was doing a 200-mile round trip sometimes for the day to sort things out, my employer at the time was not understanding at all, I couldn’t get any time off, I ended up using my holiday allowance to do that so everything was either work or looking after my dad which was gradually wearing me down to say the least. I moved on to a different lectureship where they were more understanding which was good but then my dad was diagnosed with terminal cancer and I thought I’m not handling this myself, I knew I wasn’t coping so I thought I’ll put my career on hold, I’ll look after him for the time he’s got left, it’s important for me to do that. And then that’s it, it’s over and I’ll come back to my career. But it’s a two-edged sword, yes I was grateful that he lived for another four years, but after four years there was no way back into academia. You know yourself about research profiles, four-year gap? They are not interested. So I couldn’t go back. They asked me where I had been, some almost implied I had been in prison, so it is a problem for those carers who do not claim benefits. And I’m not the only one that’s been in that situation. So returning to work was very very difficult”.

    (James)

The CReate project adviser suggested he apply for a position with a voluntary organisation. The adviser felt the post would enable James to use his research skills, but also felt that this organisation would be understanding regarding the gap in his career history due to caring responsibilities. The CReate adviser supported James to make the application, and it was successful. After nine months, he reported he was satisfied with his new role:

“I would like to, well in the foreseeable future, stay here and continue building a career, I’m at that age now, I’d say, no more career changes, charitable sector is now where I want to stay. I’ve gone home several times with a sense of satisfaction, I’ve been worried about some people sometimes, but I’d like to stay where I am for now”.

 (James)

However, he reported that he had taken a significant pay cut. Barbara reported that she pursued self-employment due to a lack of suitable flexible jobs in the area, and stated when interviewed:

“So, for a little while I was trying to find part time jobs, but I found that being honest and saying why it needed to be part time and not full time, because I was looking after my mum, people didn’t really want to know. I think they took the view that if it was a choice between somebody who needed part time work but was fairly free, and me encumbered with my mum, so to speak…..I think it would be easier (to be self-employed) so I’m answerable to myself rather than to other people. Because it does cause a lot of stress…even when I did do some voluntary work but I just found that I was having to dash backwards and forwards between that and my mum…. and because I felt that I’d made a commitment to the voluntary work, I thought if I am going to do this, I have to spend a reasonable amount of time doing the voluntary work. But then I couldn’t, I got too stressed really and I thought I’m going to have to stop it and you know, it, she (her mum) has become sort of all-consuming really”.

 (Barbara)

Barbara had decided to pursue self-employment prior to accessing the CReate project, as she had not been able to identify any suitable jobs (in design) within the area. The CReate project adviser supported her to set up her business, and after a year, they both felt Barbara was ready to commence trading. This corresponded, however, with CReate project funding ending. Barbara indicated via email, after six months, that she had not pursued generating clients, as her caring responsibilities had ‘taken over’. The short-term nature of CReate project funding, and Barbara’s caring responsibilities restricted her progress towards self-employment.

Intensive caring responsibilities, and carers’ own health, also prevented three other carers from achieving their goals. Clare, for example, found it difficult to pursue self-employment, due to her intensive caring responsibilities (she cared for her son for over 50 hours a week who had behavioural problems but had not received a diagnosis), whilst also working part-time. Clare had two home appointments with a CReate adviser over two years and had a long-term goal of setting up in self-employment. The CReate adviser provided her with motivation to pursue her goals (see quote above), and supported her (successfully), to apply for a Carer’s Small Grant[[50]](#footnote-50) to pay for a training course. Clare reported when interviewed, however, that her caring responsibilities often meant she did not have the time or energy to pursue her goals; she stated she was exhausted by 7pm most days.

She reported during the follow-up interview that she had completed the initial training course but needed to complete two more before she was fully qualified to trade. Work with the CReate project was ongoing when funding ended, as according to the CReate project adviser, Clare’s goals were long-term over a period of at least five years. Although Clare had made some progress towards her goals of setting up in self-employment, she remained in part-time employment. She reported during the second interview that she valued the financial security of her job, but wished to pursue a profession which she enjoyed, and was more flexible. For Rachel, her own health issues were a barrier to work-care reconciliation:

“…I just can’t, because of my back, I can’t travel, like that job in Bradford, I couldn’t have done that. I sat and thought about it. I mean I was devastated when they withdrew the offer, but realistically, my back, so I’ve worked on my back the last 18 months or so, doing Pilates and I’ve been swimming and I do a lot of walking, I’ve still a lot of problems with my ankle and my back”.

                                                                                                             (Rachel)

Although caring affects the health of many carers (Carers UK 2004; Hirst 2004), Rachel’s health problems were not related to caring. Rachel reported that her caring responsibilities, however, were often unpredictable (she cared for her daughter with mental health problems), which she felt also limited her ability to pursue employment. After accessing the CReate project, she did, however, join social groups and pursue volunteering. Similarly, Frank decided not to pursue employment due to his own health, although he initially wished to return to work when he accessed the CReate project:

“….I think it was not looking after myself that actually drove me into the ground and because I was exhausted mentally, it was depression, I could not see the bright side of anything. All the doors slammed shut, as I went along I realised that sort of workload (his previous job), based with the type of caring, was not compatible. Since the depression, I’ve had something which is similar to chronic fatigue, I go from hour to hour and have to lie down and do various things, that’s a legacy of the depression”.

                                                                                                     (Frank)

The CReate project adviser encouraged him to volunteer, to build his confidence, and he delivered some workshops for Carers’ Resource. Although the CReate project built his confidence (see quote above), Frank decided, and the CReate project adviser agreed, that returning to work was not a viable option at the time. Evidence from tracking ten carers through the project indicates that, although the CReate project supported carers to pursue their goals regarding work and care, external factors, such as the policy and funding context, limited the impact of the project. Reasons why carers did not achieve their goals included: carers’ own health; intensive caring responsibilities; lack of quality flexible jobs; and the short-term nature of CReate project funding. Although the CReate project provided a support service which carers highly valued, factors within the state, market, and family, affected the ability of carers to combine work and care, and the capacity of the CReate project to promote carers’ work-care reconciliation.

*To what extent did carers benefit from CReate project support?*

Evidence presented indicated that the design and implementation of CReate project services for carers can be interpreted as ‘delivering person-centred support’. Chapter 2 argued that a person-centred approach to services is important for promoting carers’ work-care reconciliation, as carers of working age are a heterogeneous group, and hold varying beliefs regarding work and care (Kröger and Yeandle 2013; Hamblin and Hoff 2012; Vickerstaff et al 2009; Yeandle et al 2007b; Arksey et al 2005). Chapter 3 outlined that effective employment support for carers is characterised by flexible and tailored support and suggested that voluntary organisations are sometimes effective at providing this support (Wigfield and Marangzov 2014; Vickerstaff et al 2009; Arksey 2003). Delivering person-centred support provided carers tracked through the CReate project with practical and emotional support to work towards their goals regarding work and care. Carers tracked and interviewed highly valued services available and several referred to it as a ‘lifeline’.

CReate project staff supported 26 carers to return to work, set up in self-employment, or remain in employment. Some groups of carers accessed CReate project support more than others; a high proportion of Pakistani/ British Pakistani carers accessed the project, who are often under-represented in services (Yeandle et al 2007a). High numbers of parent carers, who often face significant difficulty combining work and care (Stiell et al 2006; Phillips 2002), also engaged with the project. The number of carers in employment who accessed the CReate project, however, was very small. The CReate project manager acknowledged, in conversation, that this was an issue, and a factor Carers’ Resource would endeavour to improve if they secured funding to prolong the project.

Several carers reported improved confidence after accessing CReate project services. Carers of working age, and especially those who have been out of the labour market for some time, often report a loss of confidence and self-esteem (Carers UK et al 2012; Colombo et al 2011; Maher and Green, 2002). Although improved confidence does not guarantee employment, it can be an important first step for carers to return to work (Formby and Yeandle 2005; Arksey 2003). External factors, such as the policy and funding context in which the CReate project operated, however, hindered the impact of the CReate project. The support needs of some carers were long-term, and the relatively short-term nature of CReate project funding (3 years), meant that when project funding ended, several carers were still engaging with the project.

Some carers tracked found it difficult to return to work due to their own health, a lack of good quality flexible jobs, intensive caring responsibilities, and adequate and appropriate formal care services or school places. Self-employment was a popular option for several carers and CReate project staff supported six carers to set up in self-employment and commence trading. Although self-employment can give carers greater control over their working time (Gimenez-Nadal et al 2012; Kirkwood and Tootell 2008; Walker and Webster 2007; Arai 2000; Stephens and Feldman 1997), it has been associated with an increased risk of poverty and social exclusion and can have a negative psychological impact (Bunk et al 2012; Bell and La Valle 2003; Baines et al 2003).

Support through the CReate project, including one-to-one support and the Enterprise Club, which ran monthly for carers pursuing self-employment, could have helped, however, to mitigate some of the potential negative effects of self-employment. The Enterprise Club, for example, enabled carers to meet regularly with other carers pursuing self-employment, exchange ideas, and provided peer support. One-to-one support, with a CReate adviser with specialist knowledge in enterprise and self-employment, equipped carers tracked with the necessary knowledge and support to pursue a viable business idea. Carers tracked through the project who set up in self-employment and commenced trading were all highly positive regarding the flexibility and control that self-employment brought and felt supported by CReate project staff. Overall, the CReate project provided a support service which carers tracked through the project and interviewed, highly valued. It was particularly effective at building the confidence of carers and providing motivation.

## 6.3 Creating carer-friendly workplaces

This section examines the role of the CReate project’s work with employers. It examines employers’ experiences of services and the impact of CReate support for employers. It considers to what extent the design and implementation of CReate services can be interpreted as contributing to the creation of ‘carer-friendly workplaces’. A carer-friendly workplace is one which: identifies carers in the workplace; recognises the challenges that carers face combining work and care; and supports carers to remain in employment[[51]](#footnote-51).

*Creating carer-friendly workplaces in the design of CReate project services for employers*

The initial bid for funding suggests that CReate project staff aimed to encourage employers to recognise and support carers in the workplace (Carers’ Resource 2012). It states that they aimed to: “work with organisations to raise awareness of issues carers face in the workplace and develop carer-friendly working practice and flexible training opportunities for carers”(Carers Resource 2012, p.13). The CReate project manager, who was responsible for engaging with employers, also stated when interviewed that the aims of the project were:

“Engaging with employers in the first place and talking to them and putting the idea into their head, actually are you carer-friendly? Telling them about the training we can offer them and the guidance we can give around tweaking, that is all it is, just tweaking policies and procedures to make themselves carer-friendly, and then evidence that businesses have actually made changes, so they’ve actually taken on board what we’ve said, engaged with us, and actually put changes into place to support carers in the workplace”.

 (CReate project manager)

The CReate project manager aimed to contribute to the creation of carer-friendly workplaces by providing training and encouraging organisations to revise their employment policies and practices.

*Implementation of CReate project support for employers; contributing to creating carer-friendly workplaces?*

CReate project support for employers included: training on supporting carers in the workplace; developing a carers’ policy; and support to attain a carer-friendly charter mark (available in the latter stages of the project). CReate project staff employed a range of techniques to engage with employers, including: organising networking events; attending local networking events; cold calling; emailing; and sending information packs. Although the CReate project manager faced barriers to implementing support for employers in practice (examined subsequently), implementation of services can be interpreted as ‘contributing to creating carer-friendly workplaces’. CReate project engagement with Renford (a large public-sector organisation), outlined in Box 6.3 demonstrates this.

Box 6.3 Case study: Renford

Patrick from the public-sector organisation contacted the CReate project to invite them to attend an event for employees on carers and caring, following the results of a staff survey:

“The main thing that triggered it (initial contact) was a survey because we do surveys every so often and we found a staff engagement survey brought to light that people that were part time and people that were carers didn’t feel that (the organisation) were supporting them very well so I decided to do the carers event on the back of that”.

Patrick invited several local voluntary organisations, within health and social care, to attend. Employees were able to take a break from their duties to attend the event.

Contemporaneous observation of event organised by public sector organisation for employees:

*The event is in a small, dark and stuffy basement room. The CReate project manager and one other team member set up their stand and lay out leaflets and information booklets on a table. Organisations around the room do the same. Six organisations are present including condition-specific voluntary organisations, a disability advice organisation and another carers’ organisation based in the area.*

*The event runs from 10-3. A steady stream of employees attend throughout the day and CReate project staff continuously respond to queries and expressions of interest. Several employees do not initially identify themselves as a carer. To engage with people, CReate project staff ask, ‘do you look after someone?’ This is also the phrase used on promotional materials and posters displayed. After talking with CReate project staff, several employees realise they are carers but had not thought of themselves as such. As one employee stated: ‘it’s just what you do’, in relation to providing support to his elderly parents.*

*The majority of employees who attend have not heard of Carers’ Resource. CReate project staff outline the services available through the organisation as well as specifically through the CReate project. Employees help themselves to leaflets and fill in a short form if they would like further information or to arrange an appointment. Some employees become very emotional when discussing their caring responsibilities. CReate project staff are empathetic and outline potential ways that Carers’ Resource could support them.*

*At the end of the day, CReate project staff and Patrick agree in conversation that the event was effective at identifying carers and raising awareness of support and services available.*

Patrick stated subsequently when interviewed:

“Because it needed to be raised, it was a very successful event for people and a few people were leaving the room crying because they’d actually got the support that they hadn’t been able to get because they couldn’t have time outside of work to go and do it which was quite powerful”.

Following this event, Patrick, a line manager from the public sector organisation and the CReate project manager decided it would be beneficial to deliver training for line managers on recognising and supporting carers in the organisation. They agreed that Patrick would organise this, with the line manager. 20 line managers from one department, and two regional managers of the organisation, confirmed their attendance.

When asked in conversation how the training materials were developed, the CReate project manager stated they used some materials developed by other organisations, incorporated findings from research, and used personal stories and case studies. She stated she aimed for the training to be as interactive as possible, to ‘get employers thinking’. She focused on the business case for supporting carers, as she felt this would capture managers’ attention. Training materials developed included a PowerPoint presentation and an information pack for managers. The information pack contained information regarding supporting carers in the workplace, and services available through Carers’ Resource and the CReate project.

Contemporaneous observation of training delivered to line managers:

*The CReate project manager delivers the training in the same small, dark and stuffy basement room as the previous event. It lasts for one hour. Chairs are set up in rows facing the front, and the CReate project manager places an information pack and quiz sheet on each seat. Line managers wander in, chatting. When they are settled, the CReate project manager introduces herself and thanks them for attending and giving her the opportunity to speak to them today. She starts with a quiz and asks the managers to answer multiple-choice questions, individually, regarding the number of carers in the UK, the number of carers in the workforce, the savings businesses can make supporting carers, and the costs to the economy if carers leave the labour market. There are several murmurs of surprise as the CReate project manager goes through the answers.*

*The CReate project manager proceeds using the PowerPoint presentation. She outlines how to identify carers in the workplace and signs that may indicate someone has caring responsibilities. She illustrates practical ways managers can support carers in the workplace, and how the CReate project and Carers’ Resource can provide further support.*

*The CReate project manager invites questions from line managers. Several are keen to find out more and ask for practical advice on taking things forward. One of the managers mentions that employees can already apply for a carer’s passport which alerts line managers to caring responsibilities and should ensure carers receive appropriate support. Many of the managers are not aware of the carer’s passport. The CReate project manager encourages them to remind employees this is available.*

*There is concern amongst some managers that employees will take advantage of support available; they feel that people may use caring responsibilities as an excuse to take time off work. The CReate project manager emphasises the importance of open and honest conversation between employees and managers and creating a culture of trust in which employees feel comfortable to speak in confidence with their manager.*

*The CReate project manager thanks the audience for attending and encourages them to read their information packs and to get in touch if they have any further questions or would like further information.*

The case study example indicates that CReate project staff aimed to stimulate and facilitate change regarding supporting carers in the workplace. The CReate project manager worked with three other organisations (Community Trust, Tradebank and Ulearn) to develop carer-friendly work practices (examined in further detail in the following section). She also attended and organised several networking events for local businesses, to raise awareness of the importance of, and business benefits of, supporting carers in the workplace. The CReate project manager worked with employers to contribute to creating carer-friendly workplaces.

*Impact of CReate project services for employers*

This section examines the impact of CReate project services for employers and employers’ experience of services. Only four (Renford, Community Trust, Tradebank and Ulearn) of the 76 organisations contacted by the CReate project manager, committed to engaging with the project, and three to working towards implementing a carers’ policy and carers’ Charter Mark. As outlined in Chapter 4, Renford is a large public-sector organisation, Community Trust is a voluntary organisation, Tradebank is a bank and Ulearn is an education establishment. Interviewees in these organisations highly valued the support available through the CReate project. A line manager at Renford felt training delivered by CReate project staff increased her knowledge regarding supporting carers in the workplace, and alerted line managers to existing support available within the organisation. She stated when interviewed:

 “I do not think we’ve ever looked back from it, I think it was very, very good (CReate project training delivered), it was educational for us, and I was aware of certain things but there were an awful lot of people who didn’t know anything, even managers didn’t know some of the things that were there and available, it’s been brilliant”.

                                                                     (Line manager, Renford)

A line manager from Community Trust emphasised the dedication of CReate project staff and her support for the carers charter mark offered by CReate. She stated when interviewed and asked about her experiences of working with CReate:

Very good, I think they are a good team there, I have known (CReate project manager) for a long time. But everybody there seems to be very conscientious and really keen to get this out there, so, I think it’s a really good organisation. They’re supporting us to work towards the charter mark, which is something I’m really keen to get endorsed.

 (Line manager, Community Trust)

Following engagement with the project, the four organisations made some changes to their employment practices, including: introducing a carers’ champion; starting a support group for carers; introducing a carers’ policy; and working towards attaining the carers’ charter mark. Patrick at Renford reported, when interviewed, that managers had implemented several changes following CReate project training. He stated that Renford now circulate a monthly newsletter, which includes an overview of support available for carers in the local area. According to Patrick, he also circulated a ‘condensed version’ of the training presentation delivered by the CReate project manager (which provided advice on identifying and supporting carers in the workplace), to all the organisation’s offices nationally. He reported, when interviewed, that distributing the training resulted in changes to organisational policies to support carers, and greater parity of support across the organisation’s offices:

“What happened with the training package was, I revised it, so I got rid of the local stuff and then I presented it to a higher management board and then that went to nine sites. So although CReate didn’t deliver the package, I passed it on so it did actually impact on a higher level. It went down really well and they put policies in place now to support people a lot better, so that all sites are equal”.

                                       (Patrick, Renford)

Patrick also indicated that, following CReate project training, Renford appointed a carers’ champion and introduced a designated health and well-being room for employees with information regarding local support available, including around caring. An information officer at Carers’ Resource developed a partnership with the carers’ champion. According to the information officer, she acts as a named contact for the carers’ champion or Renford employees, if they have any queries regarding caring or support and services available. Patrick felt that appointing a carers’ champion ensured that employees with caring responsibilities, received appropriate support:

“…(carers’ champion) had one lady just after Christmas whose father was really ill, and she needed support, so we referred her to Carers’ Resource directly through (carers’ champion) and it got sorted. Her father has since passed away, but her mother still needs support, so she’s actually got that now. I think it (Carers’ Resource) pushed social services a lot faster to deal with what they needed to do, and her not having that link would have been quite traumatic because it was a difficult time for her. So, it is a very positive thing, having that in place (carers’ champion and link with Carers’ Resource), which obviously has not been done before (at Renford). We’ve also kept up with the leaflets and the actual physical support, the open door with (carers’ champion) and the contacts, it’s enabled them (employees with caring responsibilities) to have the right amount of support I think”.

 (Patrick, Renford)

The Renford line manager interviewed also reported that CReate project training had prompted an increase in the uptake of carers passports:

“Suddenly we got an influx of applications (for the carer’s passport). Sometimes you have to sit with people and discuss why the need to put one in place, but all that came out of the (CReate project) training, the training helped us with all that, so it was good”.

                                                                (Line manager, Renford)

According to the line manager, carers passports ensure the organisation is aware of those with caring responsibilities and that they provide appropriate support. After accessing CReate project support, Renford made several changes to their workplace practices, which aimed to improve support for carers and contribute to creating a carer-friendly workplace.

 The CReate project manager also worked with line managers at Community Trust, Tradebank, and Ulearn, to develop a carers’ policy and support them to attain the carers’ charter mark. The CReate project manager was still engaging with these organisations, however, when CReate project funding ended. When funding ended, none of the organisations had yet implemented a carers’ policy in practice or gained the charter mark. Although the CReate project manager reported she would continue to work with these organisations regardless, she retired shortly after. According to the manager, another member of staff took responsibility for providing support to employers, but this was after the data collection period for the thesis. Employers that engaged with the project highly valued the support available, and organisations made some changes towards becoming carer-friendly workplaces. The short-term nature of project funding, however, limited the impact of CReate project support for employers.

The CReate project manager also faced several challenges to engaging with employers and did not feel they had yet found an effective technique for engaging with employers. She stated, when interviewed, that she did not feel employers recognised the benefit of retaining employees with caring responsibilities:

 “It was just engaging with them (employers) in the first place, you know we’ve tried different techniques, us going to them just doesn’t work. For them, the incentive of keeping someone in the workplace does not seem to be of value. So, we just haven’t found that technique yet with engaging with employers so that’s a real big challenge”.

                                                                            (CReate project manager)

Similarly, the Carers’ Resource Director, when interviewed, expressed frustration at employers’ lack of engagement with the CReate project following an event with Princess Anne[[52]](#footnote-52).

 “You do not need me to tell you the lengths I went to for the Princesses’ visit. But surely that must reveal something, they (local employers) came, they saw and they walked. How do we turn it into a real issue?”

                                                                        (Director, Carers’ Resource)

The Carers’ Resource Director felt that employers would be more likely to engage with the project, if carers had greater legal stature:

“I am not sure that there is yet enough directive for employers to have to think about carers. Someone once said to me, and it’s turned out to be very true, to get carers issues onto employers’ agenda, this is where people like Carers UK and EFC (Employers for Carers) are going to be doing their work, on a top-down basis, there needs to be a certain amount of legal expectation. The new Care Act is going to make it more inherent, so everything is moving slowly in the right direction. But at a local level, you will have observed, it is quite difficult still to get employers truly to recognise (the importance of supporting carers in the workplace).

                                                                        (Director, Carers’ Resource)

The CReate project manager also shared two email responses from HR departments in local organisations, after she had contacted them regarding the benefits of supporting carers in the workplace, and the services available through CReate. One stated that, although they recognised that supporting carers is important, it is not currently a priority for HR. The other stated that, they felt they met the ‘legal requirements’ of supporting carers and did not feel they needed further support.

CReate project staff also faced several practical barriers to engaging with employers. Resources, in terms of personnel, were an issue, as the CReate project manager only worked 20 hours a week and was also responsible for managing the Carers’ Resource office in Bradford. She had limited time to dedicate to engaging with employers, which she stated was time-consuming, and required persistence and active engagement to keep momentum. Work with the organisation outlined in Box 6.3, for example, was ongoing over 18 months. Patrick at Renford, reported, when interviewed, that organising the training session for line managers took considerable time and effort:

 “It was quite stressful, it took longer than I wanted (to organise the CReate project training session). I thought I’d be able to organise it within a couple of months and I think it was from March until June, it took a few months to get sorted. I had to go through a manager and I had to attend the house committee meeting to discuss it. We have a big meeting every two weeks to discuss any issues, I had to go to that, and I had to go to a connections meeting, which is the engagement side of things. I had to discuss it with health and well-being and other groups, just to get the department I work in and another departments to actually attend it and get a date”.

                             (Patrick, Renford)

The CReate project manager also stated she primarily aimed to engage with large private sector companies in Bradford, as they are least likely to support carers (Dex and Smith 2002). This could partially explain the low number of employers who engaged with the project. Although organisations which accessed CReate project services for employers highly valued the support available, CReate project staff found it difficult to initially engage with employers.

*To what extent did employers benefit from CReate project support?*

The CReate project manager aimed to support employers to support carers in the workplace and deliver training for line managers. Previous research indicates that there are many business benefits to supporting carers in the workplace, including: increased staff productivity; increased staff retention; and reduced sick leave (Carers UK et al 2013; Yeandle et al 2006; Crompton et al 2003; Dex and Smith 2003; Bond et al 2002). According to Yeandle et al (2003), training for line managers is essential for supporting carers in the workplace. Although only four organisations engaged with the project, they highly valued the support available through the CReate project. Employers (and Renford in particular) made some changes to their working practices after engaging with the project. Changes included: appointing a carers’ champion; implementing a carers’ policy; establishing a carer’s support group; and working towards attaining a carers’ charter mark. All four organisations had made positive changes regarding recognising and supporting carers in the workplace. The funding context, however, affected the extent employers benefitted, and the potential impact of the CReate project, as work with all organisations was ongoing when CReate project funding ended. Consequently, it is also not known whether accessing the CReate project had a longer-term impact on factors such as staff retention, productivity or reduced sick leave in these four organisations.

## 6.4 Summary

The chapter provides unique, in-depth insight into the specific role voluntary organisations can play in promoting carers’ work-care reconciliation. It sheds light on how one organisation (used as a case study example), delivers work-care reconciliation support for carers and training for line managers, in practice. The chapter demonstrates that the concepts ‘delivering person-centred support’ and ‘contributing to creating carer-friendly workplaces’, help us understand the role voluntary organisations can play in promoting carers’ work-care reconciliation. The CReate project provided a support service which carers and employers who accessed the project, highly valued. CReate project staff were more effective at engaging with some groups of carers (BAME carers and parent carers) than others (employed carers).

Carers tracked through the project reported several benefits of accessing CReate support, including: increased confidence; increased motivation to pursue goals; CV writing and application writing skills; meeting other carers; and access to information regarding work, learning, training, and volunteering. The project supported some carers to return to work or set up in self-employment. The chapter indicates that although the CReate project manager faced barriers to engaging with employers, those who did engage, made changes towards becoming carer-friendly workplaces. Evidence from the case study also suggests, however, that factors within the state, market, and family, limited the impact of the CReate project. The following chapter builds on this one and examines the specific social processes, practices, and relationships important for understanding the role of the CReate project in supporting carers, to develop a theoretical understanding of the role voluntary organisations can play in promoting carers’ work-care reconciliation.

# Chapter 7: Understanding the role of the CReate project in promoting carers’ work-care reconciliation

## 7.1 Introduction

Chapter 6 examined the specific role voluntary organisations can play in promoting carers’ work-care reconciliation using the case study of the CReate project. It demonstrated that the CReate project promoted carers’ work-care reconciliation by ‘delivering person-centred support’ and contributing to ‘creating carer-friendly workplaces’. Although some previous research has considered the role of voluntary organisations in promoting carers’ work-care reconciliation (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011a, 2011b; Vickerstaff et al 2009; Yeandle and Starr 2007; Formby and Yeandle 2005), these authors do not attempt to theorise the relationships important for understanding how voluntary organisations can support carers to combine work and care or return to work. This chapter seeks to fill this gap in the literature, and answers the main question:

* How can voluntary organisations promote work-care reconciliation in a way which benefits both carers and employers?

And the sub-question:

* Over the lifetime of the project, how and why did the relationships between CReate project staff and other organisations involved shift and change?

The chapter considers how the concepts, ‘policy implementation’, ‘partnership working’, and ‘social inclusion’, outlined in Chapter 3, help us understand the role of the CReate project in promoting carers’ work-care reconciliation. It uses the concepts of ‘an ethic of care’ and ‘civil society’, also defined in Chapter 3, to explain how the CReate project could promote work-care reconciliation in a way which benefitted both carers and employers. The chapter draws on evidence from tracking ten carers and ongoing observation of CReate project services. Data from interviews with carers, employers, Carers’ Resource staff and partner organisations are also drawn on. Constructivist grounded theory enabled theoretical concepts to be developed regarding the role of the CReate project in promoting carers’ work-care reconciliation, and the longitudinal approach used was particularly effective at illuminating social processes important for understanding the role of the CReate project (Corden and Millar 2007; Neale and Flowerdew 2003).

The chapter is organised as follows. Section 7.2 examines the ways CReate project staff implemented services, and how implementing services this way promoted carers’ work-care reconciliation. Section 7.3 explores the importance of partnership working for understanding the role of the CReate project in promoting carers’ work-care reconciliation. Section 7.4 examines the role of CReate project staff promoting social inclusion to support carers. These three sections all consider the prevalence of the principles of an ethic of care in the design and implementation of CReate project services, and the role of an ethic of care in understanding how the CReate project supported carers’ work-care reconciliation. They also draw on the concept of ‘civil society’ to explain how and why the CReate project could promote carers’ work-care reconciliation in practice. Section 7.5 summarises the key findings and arguments of the chapter.

## 7.2 Policy implementation

‘Policy implementation’ is the first concept important for understanding the role of the CReate project in promoting carers’ work-care reconciliation. In the thesis, policy implementation is defined in relation to the four moral principles of an ethic of care; attentiveness, responsibility, competence, and responsiveness (Tronto 1993)[[53]](#footnote-53). This section examines the strategies and practices CReate project staff used to implement services for carers and employers, and considers the importance for delivering person-centred support, creating carer-friendly workplaces, and promoting carers’ work-care reconciliation. It explores to what extent the moral principles of an ethic of care help us understand the role of the CReate project in supporting carers’ work-care reconciliation and uses the concept of ‘civil society’ to shed light on how CReate project staff delivered services in a particular way.

The way Carers’ Resource designed the CReate project reflects the principles of attentiveness, responsibility, and competence of an ethic of care. Carers’ Resource staff recognised that carers in Bradford face several barriers to work-care reconciliation (attentiveness) and applied for BIG Lottery funding to provide services to promote carers’ work-care reconciliation (responsibility). As the CReate project manager stated when interviewed:

“When we put the bid in, we told BIG Lottery about where we saw the shortcomings were in Bradford for carers with issues around work and learning, we told them what we’d been delivering through the Changing Lives project (a previous work-care reconciliation support project) and felt that that model could fit”.

 (CReate project manager)

Carers’ Resource were not obliged to provide services for carers and employers, as a commissioning requirement for example, but decided to provide support on their own volition. From an ethic of care perspective, providing care should be a wish, and not an obligation (Tronto 2003; Sevenhuijsen 1998). The BIG Lottery Fund also did not stipulate the design of the project or how to deliver services. The BIG Lottery grant manager stated when interviewed:

“Outcomes and indicators are set by organisations themselves when they bid for funding. If things aren’t working then they can change things round, but if they get the indicators then they should get the outcomes. If someone wants to change an outcome, this has to go back to the committee, but outcomes are completely up to the project”.

 (BIG Lottery grant manager*)*

Similarly, the trustees, responsible for governance of the CReate project, did not specify the services they should deliver, or how. One of the trustees reported when interviewed:

“No, we don’t get involved in the fine detail of what is delivered, there’s an important distinction that the executive function is the executive function, the non-executive function is oversight, not the detail, we’re allowed to ask questions about the detail and we often do if something looks odd, or we think that something’s been missed, we’re perfectly entitled to do that, but it would not be appropriate for us to do (CReate project manager’s) job for her”.

 (Trustee, Carers’ Resource)

In line with the concepts ‘attentiveness’ and ‘responsibility’ of an ethic of care, Carers’ Resource recognised that carers often face several barriers to work-care reconciliation and took responsibility to provide support. There was no obligation to provide this support and CReate project services were not commissioned or stipulated by a governing body but were based on previous experience of delivering work-care reconciliation support projects.

The design and implementation of CReate project services also reflect the principle of ‘competence’ of an ethic of care. Competence refers to the appropriateness of services and the expertise and skills of personnel to deliver services (Tronto 1993). As outlined in Chapter 6, the CReate project promoted carers’ work-care reconciliation by delivering person-centred support and working with employers to create carer-friendly workplaces. Evidence from the case study and previous research indicates that these are appropriate services to deliver. As carers are a heterogeneous group and have varying preferences and support needs regarding work and care, a person-centred approach to service delivery is important (Kröger and Yeandle 2013; Hamblin and Hoff 2012; Vickerstaff et al 2009; Yeandle et al 2007b, 2007d; Arksey et al 2005). Carers who are out of the labour market for a significant period of time often feel that their skills are out of date and wish to undertake training (HoCSC 2008). According to Yeandle and Wigfield (2011a), effective training for carers is provided in an informal environment, by those empathetic to caring responsibilities.

CReate project staff and volunteers with an understanding of the support needs of carers provided training and workshops on a range of topics (see Chapter 5, Table 5.3 for overview). Chapter 2 indicated that line managers also play a vital role in promoting carers’ work-care reconciliation (Hamblin and Hoff 2012; McCarthy et al 2010; Hegewisch 2009; Higgins et al 2008; Yeandle et al 2003; Glynn et al 2002; Yeandle et al 2002; Lewis 1997) and the CReate project manager provided support and training for line managers to work towards becoming carer-friendly workplaces. Evidence from the CReate project outlined in Chapter 6 indicates that carers and employers who participated in project services, highly valued the services available. Delivering person-centred support and working with employers to create carer-friendly workplaces, were appropriate services to deliver, although CReate project staff faced difficulty engaging with employers.

CReate project staff were also ‘competent’. The three CReate project advisers and the CReate project manager who delivered services during the data collection period were highly qualified; they had extensive experience of delivering employment support and providing support for carers (see Chapter 5, 5.5). Although one CReate adviser did not have this expertise, he completed a month-long intensive induction programme to develop his understanding of Carers’ Resource and the support needs of carers. He also had previous experience of working with what the CReate project manager termed ‘vulnerable groups’, which she felt had enabled him to develop transferable skills. The CReate project manager herself had considerable experience working with carers (over 10 years) (see Chapter 5, 5.5) and stated she kept up to date with the latest research regarding work-care reconciliation. The volunteers who delivered the IT groups both reported when interviewed, that they had previously had long careers in IT and were also carers, so understood the difficulties carers can face. The CReate project did, however, face significant difficulty with staff retention and turnover, examined in detail in Chapter 8. In accordance with an ethic of care, services delivered for carers and employers were appropriate and CReate project staff were competent. Evidence presented indicates that the design and implementation of CReate project services were characterised by attentiveness, responsibility, and competence.

The competence of CReate project staff was important for delivering person-centred support, working with employers to create carer-friendly workplaces, and promoting carers’ work-care reconciliation, in practice. Returning to the case study example of Pat, outlined in Chapter 6, the competence of the CReate project adviser was important for delivering person-centred support, and supporting her to return to work. The adviser’s expertise regarding job applications and interview techniques ensured she provided appropriate support, and enabled Pat to pursue her goals. Pat stated regarding her job interview: ‘I couldn’t have done it without her’. Other carers tracked through the project also appreciated the expertise of CReate project advisers:

 “(Adviser) had that background of having run her own business and of having been part of (business start-up organisation), and so she had a lot of detailed information, business information, which I found really helpful”. (Louise*)*

“It was very supportive, knowing that there’s someone I could ask anything that I was unsure about, usually related to tax or (adviser) gave me, for example, how much mileage I could charge, to put on my accounts and things like that, which I didn’t know. ….So it’s things like that, and just knowing that they’re there on the end of a phone is quite reassuring”.

 (Natasha)

“She’s (adviser) just so full of knowledge, isn’t she? Especially when myself, I seem to have had a very fixed perspective, and she’s been able to put a lot of different perspectives in place and made me look at the wider picture. I’m getting to that age that it’s too safe sometimes to just look at playing sage and going by what you know all the time and thinking that I’m always right. Because I am a bit like that, it’s making me look at different options.” (Barbara)

The expertise, or competence, of CReate project staff was important for supporting carers to pursue their goals and make decisions regarding work and care. The volunteers who delivered IT groups were patient and approachable and had extensive knowledge of IT and an understanding of caring responsibilities. One carer stated, for example, they were, ‘happy to go over things several times’, and a few carers within one session observed felt they would have a better understanding of how to use computers, if they understood some of the mechanics. The volunteer explained, in lay terms, how a hard drive works, and the basic elements which make up a computer. Similarly, employers who engaged with the CReate project valued the manager’s expertise. The line manager of Renford stated when interviewed:

“It (the training delivered by the CReate project manager) highlighted a lot of things, it educated people as to what carers are because a lot of people don’t consider themselves to be carers, and I think it brought out realisation maybe, that yes, I am a carer, because this is what I do, people take it for granted that that’s their role. But there is a lot of help out there for them when they know and I think the training helped us highlight that to people”.

 (Line manager, Renford)

The expertise of the CReate project manager and Carers’ Resource development manager, were also important for supporting Ulearn to develop a carers’ policy and carer support group. The manager from Ulearn interviewed, stated she had little knowledge of the support needs of carers (prior to engaging with the project), and highly valued the expertise of Carers’ Resource staff (both had over 10 years’ experience of working with carers around work-care reconciliation), in developing the policy. In relation to setting up a workplace carer support group, the Ulearn line manager stated when interviewed, ‘Carers’ Resource have been supporting me with it (carer support group), which is great because I don’t necessarily know where I’m going with it’The CReate project manager made suggestions, based on previous successful support groups, of how to proceed. She reported that a couple of structured sessions to begin with, and subsequently following carers’ lead, had been a format which had previously been effective and ensured carers’ eventual ownership of the group. The expertise and skills, or competence, of CReate project staff, were important for delivering person-centred support and contributing to creating carer-friendly workplaces.

Trust and reciprocity (also central to an ethic of care), however, are also important for understanding how CReate project staff implemented services and promoted carers’ work-care reconciliation. Trust was a reason for which carers initially engaged with the project. Pat, for example, re-contacted the CReate project due to a previous positive experience with a CReate adviser:

“(CReate adviser) was just fabulous, she was really up-beat and she did lots of job searches with me and, because I hadn’t done that for years, eight or nine years. And she was all ‘come down and we’ll have a look at your CV and I’ll get some job things going’”. (Pat)

Carers tracked through the project and interviewed, indicated they were more likely to trust and engage with the CReate project, than statutory services:

“I decided I’d had enough of the Jobcentre and decided to try and do this on my own. When I saw her (Jobcentre adviser) I was so frustrated because I’m hanging about for stuff and because I’m not going online enough[[54]](#footnote-54), they’re threatening to stop my money. I was just so frustrated that day and I said, ‘what am I supposed to do?’ I said ‘yes, with my qualifications I can get a job tomorrow, but I can’t cope with a job at this particular moment, so I said what you do want me to do? Because I can hardly get out of the house, what do you want me to do?’ I freak every time I go there. But as soon as I’d finished I called in (to Carers’ Resource) and just said is there somebody that can help me please? They were so good and they just gave me the confidence to come back again”

 (Carol)

“I attended a CReate project open day as I want to return to work. I would like some money so that I can have a bit of self-respect really and try and get off the benefits system. Because I do find it soul destroying really. At least I don’t have to go to the Jobcentre any more. That is awful. When I first started going, it wasn’t too bad, but I think they changed the system and after a few months, you’d be waiting hours. I’d turn up promptly for my appointment because you had to, but yet, I could be kept waiting at least an hour before I saw anybody and then they treated me like, they talk to you like dirt to be honest, talk down to you a lot, you have to do a lot of justifying, so I didn’t like that”.

 (Barbara)

“I’m on ESA (Employment and Support Allowance), you’re allocated a personal adviser who in theory meets with you and gives you support and advice. People at the Jobcentre are just overwhelmed by the amount of work they’ve got. And I think they’re doing a really difficult job a lot of the time. So, in theory you are meant to get the support perhaps that CReate is providing through the Jobcentre, but I just don’t think they’ve got the resources”.

 (Louise)

Although carers may have felt they had no choice but to seek alternative services due to their negative experiences of statutory support, carers indicated they felt comfortable accessing CReate project services, and felt services were more appropriate for their needs. Similarly, trust was important for the CReate project manager to engage with employers. Three of the four employers who engaged with the project had previous experience of working with Carers’ Resource and had already built relationships with the organisation. The line manager from Community Trust stated, when asked how they became involved with CReate:

“I’ve been involved for a number of years. Part of what we used to offer was IT training so I used to deliver some courses on their behalf and that’s how I got involved with Carers’ Resource. And then for CReate, because we are a voluntary organisation ourselves, we were asked to join the advisory group (CReate employer’s advisory group), (CReate project manager) asked me to come on board”.

 (Line manager, Community Trust)

Patrick from Renford stated, when asked the same question:

“I’ve been a carer for years, so caring has always been something that I’ve been aware of and I’d worked a little with Carers’ Resource when I worked for (local voluntary organisation) as a networker, so I was obviously aware of them when I started my role here, so that’s obviously how I linked with them.”

 (Patrick, Renford)

Reciprocity, in terms of the ability and willingness of carers and employers to participate in service delivery (in line with responsiveness of an ethic of care) were important for the CReate project to implement services and promote carers’ work-care reconciliation. Pat, for example, who returned to work, could fully engage with the project and attended all appointments arranged with the adviser. Observations also indicated that both Pat and the adviser completed the tasks agreed during appointments, such as identifying suitable roles to apply for, and so participated in service delivery. The impact of the CReate project was limited when relationships were not characterised by reciprocity and carers were unable to engage in service delivery. The case study of Clare, tracked through the project[[55]](#footnote-55), outlined in Box 7.1 demonstrates this.

Box 7.1 Case Study: Clare

Clare cares for her son who has autism, attachment disorder, and behavioural problems. She also cared for her husband who had cancer and recently died. A Carers’ Resource caseworker referred Clare to the CReate project as she was finding it difficult to combine work and care. She stated when interviewed:

 “So, it’s very very intense, it (caring) started at quarter to six in the morning, getting myself up and getting myself ready and you went onto (husband) and doing all the stuff that he needed doing and then you went on to (son) and getting him off to school and everything and making sure (husband) had everything, then after (son) had gone to school it was just me going off to work, making sure I’m getting there on time, making sure I’m getting my job done, which is getting more and more difficult”.

Clare reported she worked part-time, four days a week, and with shortened hours so she could collect her son from school. She felt, however, that her employer was not always understanding when she had appointments to attend or had to suddenly leave work if an incident at school occurred. She stated when interviewed, “….and then you’ve got to say, ‘I’ve got to go’, and I think they just sometimes think that carers are making it up and it's just a white lie”.Clare had two one-to-one appointments with a CReate adviser, one a year.

During the first meeting at Clare’s home, the CReate adviser reminded Clare of her rights in the workplace and wrote a letter for her to give to her employer confirming she is a carer and outlining the extent of her responsibilities. Clare reported this had helped in the short-term, as it opened dialogue between her and her manager. She indicated, however, that the organisation had experienced significant turnover recently, particularly at management level, and she found it difficult to go through the process of explaining her situation several times. Clare had recently arranged with her manager to decrease her hours as her son’s transport to school had been unreliable, but she thought this would be temporary.

According to Clare, her long-term goal was to pursue self-employment, which she felt would enable her to work more flexible hours, align her job with her interests, and be more sociable.

During the second meeting observed, the CReate adviser supported her to apply for a Carer’s Small Grant to cover fees of a training course she needed to pursue self-employment further. The application was successful, but she had not completed the course when the period of data collection ended. Clare reported in a follow-up email that this was due to her demanding caring responsibilities. She also stated that she remains in her current employment and is still finding it difficult to combine work and care.

In this case, services were not always characterised by reciprocity. Clare found it difficult to maintain engagement with the project and sometimes did not have the time or energy, due to her caring role, to focus on her employment goals. As Clare’s caring responsibilities were intensive (over 50 hours a week), she was unable to commit to engaging with the project on a regular basis and found it difficult to complete her agreed tasks. Observations indicated, for example, that she missed the first deadline for applying for the Carer’s Small Grant and cancelled or rearranged several appointments with the CReate adviser. Clare’s inability to engage with the CReate project limited her progress towards achieving her goals regarding work and care.

Similarly, evidence from observations of IT groups (see Box 6.2 Chapter 6), indicates that the competence of volunteers, alongside trust and reciprocity, were important for promoting carers’ work-care reconciliation. As indicated in Chapter 6, observations of this IT group revealed that carers developed relationships as the weeks progressed, which enabled them to work together and exchange advice. The IT group used as a case study example also had good attendance from carers, however, which enabled these relationships to develop. CReate project staff reported they had cancelled several other workshops due to low confirmation of attendance rates. Sufficient resources in terms of personnel, time and equipment were important for CReate project staff to deliver workshops in line with an ethic of care. The CReate project had sufficient resources to deliver IT groups as volunteers were willing, and able, to dedicate their time to facilitating the groups, and laptops were available for all carers who attended[[56]](#footnote-56). Promoting workshops and training took a considerable amount of CReate project staff’s time, as one CReate project adviser recounted when interviewed:

“I mean, putting workshops on is always quite well known to be a bit of a challenge really but when you’re doing them for carers, it is doubly difficult. Actually getting people through the door has been a real challenge. I’ve got another three sessions booked and I’m just going to have to do it all over again. I was publicising it absolutely everywhere I could think of and just getting four people, and up to the week before thinking I’m going to have to cancel it, there’s nobody going to come. I think that it’s a lot work and you feel like you’re banging your head against the wall really, and then people find it (workshops) really useful, so then want to do it again”.

 (CReate project adviser 1)

Sufficient resources were important for reciprocity in practice. Reciprocity also helps us understand how the CReate project supported employers to create carer-friendly workplaces. The CReate project manager delivered training for line managers at Renford as Patrick had gained the support and commitment of a senior manager within the organisation. Patrick stated when interviewed:

 “If you can get the buy-in from their manager, somebody that they have to report to, if you get them to buy-in and they know they’ve bought in, their team will be more likely to attend (training). But if you sell it to them, that’s what I did, I went to their meeting and sold it to the manager and spoke to the manager directly and I went to my higher manager, they bought in and were quite happy. What helped especially was that I got a really high manager to buy in and because he bought in, others felt obligated to go (to the training)”.

 (Patrick, Renford)

Observation during the training session also indicated that the participation of line managers was important for improving their knowledge of the support needs of carers. The interactive quiz the CReate project manager opened with, for example, (see Chapter 6, Box 6.3) required the input of line managers. The answers initiated a reaction of surprise and interest. ‘Policy implementation’, defined in relation to an ethic of care, is important for understanding how the CReate project delivered person-centred support, contributed to creating carer-friendly workplaces and promoted carers’ work-care reconciliation. The design and implementation of CReate project services reflect the principles of attentiveness, responsibility, and competence. Trust and reciprocity were also important for delivering services in this way and promoting carers’ work-care reconciliation.

*Civil society and CReate project service delivery*

The forms, norms, and space of civil society are conducive to implementing services in accordance with the principles of an ethic of care. According to some (Cook, 2007; Hansmann 1980, 1987; Weisbrod 1988), voluntary organisations (forms of civil society) form to fill gaps in statutory and market services, or to respond to previously unrecognised needs. This suggests that voluntary organisations often recognise the gaps in service provision (attentiveness) and take responsibility to provide that support (responsibility). The voluntary sector also has a highly qualified workforce (competence) (Rees et al 2016). Some authors argue that civil society provides the space where people can come together in associational life and tackle difficult issues, such as work-care reconciliation (Edwards 2011, 2005; Fraser 1992; Gramsci 1971; Habermas 1962). Civil society, for example, provided the space where the carers’ movement could form (Cook 2007), and where Carers’ Resource formed to provide support for carers. According to Edwards (2011), civil society is also characterised by social norms, such as trust and reciprocity and some authors (Anheier and Kendall 2000; Weisbrod 1988; Hansmann 1980) argue that people are more likely to trust voluntary organisations over others, as they do not seek to generate profit, and form to provide services to beneficiaries (Anheier and Kendall 2000; Weisbrod 1988; Hansmann 1980).

Some previous research suggests that policy implementation in relation to an ethic of care is important for understanding the role voluntary organisations can play in promoting carers’ work-care reconciliation; some voluntary organisations have been delivering work-care reconciliation support for carers (attentiveness and responsibility), and can be effective at doing so as they: deliver on-going, flexible support; have competent staff; are reliable and accessible; work in partnership; and have local knowledge (in line with competence) (Wigfield and Marangozov 2014; Vickerstaff et al 2009; Arksey 2003). Some previous research (Vickerstaff et al 2009; Yeandle and Starr 2007) also emphasises the importance of trust and reciprocity for voluntary organisations to promote carers’ work-care reconciliation.

Evidence from the CReate project supports previous research which indicates that a few voluntary organisations have recognised that carers often need support to combine work and care and have taken responsibility to provide support. Evidence from the CReate project indicates that policy implementation in relation to an ethic of care is indeed important for understanding the role voluntary organisations can play in promoting carers’ work-care reconciliation and demonstrates how the moral principles of an ethic of care are important for promoting carers’ work-care reconciliation in practice. The forms, norms and space of civil society help us understand how the CReate project promoted carers’ work-care reconciliation; civil society is conducive to implementing services characterised by the principles of an ethic of care.

## 7.3 Partnership working

Partnership working is the second concept important for understanding the role of the CReate project in promoting carers’ work-care reconciliation. Partnership working is defined in the thesis in relation to the principles of mutualism and autonomy of an ethic of care[[57]](#footnote-57). Mutualism refers to recognition that human beings are dependent on each other (Williams 2002) and autonomy to recognition that human capacity develops through relationships (Mackenzie and Stoljar 2000; Young 1997). CReate project staff worked in partnership with a range of organisations to implement services (see Chapter 5, Table 5.4) and partnership working was important for several aspects of CReate project service delivery. Working in partnership helped Carers’ Resource staff engage with carers and generate referrals to the CReate project. According to the CReate project evaluation report, 34% of CReate project referrals were from external organisations (Carers’ Resource 2016). Although most carers self-referred to the CReate project, Carers’ Resource monitoring data indicates that carers often heard about Carers’ Resource through partner organisations, such as local GP surgeries or other voluntary organisations (Carers’ Resource 2016). Yeandle and Wigfield (2011b) emphasise the importance of partnership working to generate referrals and reach carers who are not already aware of services.

CReate project staff worked in partnership with internal and external partners to implement services in practice. If a carer, for example, required support beyond the remit of CReate project staff, they would often be referred to another department of Carers’ Resource, or a trusted partner organisation. Carol, who was tracked through the project and cared for her friend and housemate with autism needed specialist benefits advice, which CReate project and Carers’ Resource staff, were not qualified to provide. The CReate project adviser referred her to a Jobcentre Plus adviser who attended Carers’ Resource offices monthly (the development of this relationship is considered subsequently). Following the appointment, Carol confirmed she was now receiving the correct benefits. Similarly, Natasha required information regarding appropriate accommodation for her uncle and the CReate adviser referred her internally to Carers’ Resource casework team[[58]](#footnote-58) for advice. Internal and external partnership working ensured that carers received the support they required to pursue their goals around employment, learning and training. In line with ‘autonomy’ of an ethic of care, they recognised the importance of partnership working for developing carers’ agency. The case study of Barbara[[59]](#footnote-59) in Box 7.2 further illustrates this

Box 7.2 Case Study: Barbara

Barbara (56) cares for her mum who has dementia and suffers from heart failure. When she contacted the Carers’ Resource she had been a full-time carer for four years, after she was made redundant. Previously, she had worked in design for thirty years. She contacted a CReate adviser as she wished to set up her own business as a freelance designer, to have a life of her own and independent income, whilst also being able to care for her mum. She stated:

“I’m very aware that she’s not going to be around forever and that I do need to have some work, and I want to work as well, I want to be productive, for my own sanity really”.

She was initially unsure how to set up in self-employment. She reported she had lost confidence being out of the labour market and felt socially isolated. She also felt she needed motivation to pursue her goals:

“I felt quite isolated as well, you know, because I don’t have any help looking after my mum so I had become quite isolated and I do need people to motivate me really, I do need motivation. When you get to a certain point, it’s difficult to do that yourself so, I’ve always been good at bouncing ideas off other people”.

Prior to setting up her business, Barbara was unsure how starting to trade would impact upon her benefits (she was claiming Carer’s Allowance). The CReate project adviser referred her to the Jobcentre adviser for advice. Barbara also felt that a key way to generate clients and promote the business, would be to create a website. As the CReate adviser did not have expertise in this area, she referred Barbara to another local voluntary organisation which specialised in business start-ups and provided web-design support free of charge. Additionally, during Barbara’s engagement with the CReate project, her mother’s illness worsened, and she was struggling with her caring role.

As a result, she felt she did not have the time or energy to concentrate on developing her business. The CReate adviser referred her to Carers’ Resource casework team. Barbara reported they provided her with support and advice regarding her caring role and assisted in finding appropriate respite care. After several months of engaging with the CReate project, Barbara felt more confident and motivated to pursue her goals. She stated, ‘I know the deadline is coming up for the next thing, you know, for the next meeting so it does, it does motivate me to do things’.

Partnership working was important for delivering person-centred support and ensuring that Barbara received the support and information required to pursue her aims regarding self-employment. Similarly, the relationship, or partnership, between CReate project staff and beneficiaries was important for delivering person-centred support. A person-centred approach advocates delivering services ‘with’ and not ‘for’ beneficiaries services (Brooker and Latham 2016; Parley 2001). Evidence from observations indicated that CReate project staff treated carers tracked through the project with respect, and as intelligent individuals. Several carers felt they were participants in services (see Chapter 6 Section 6.2) and working in partnership with CReate advisers was highly valued by several carers. Frank stated when interviewed, “so it was all a case of have a go, encouragement, rather than saying, ‘you’ve got to do this’, and that sort of gave me little bits of confidence”.

Pat reported that she gained confidence updating her CV and writing application forms, as she developed them in conjunction with the CReate adviser; the CReate adviser provided templates and advice on the style of writing to use, but they developed the documents in partnership. Pat would write a draft, the CReate adviser would make recommendations, and this process continued until both were satisfied with the end products. Observations indicated this was empowering, as Pat realised she had the ability produce these documents but was just out of practice. Furthermore, she reported that outlining her employment history and skills learnt through caring, built her confidence, as she recognised she had not ‘just been a carer’*.* Delivering services in partnership with carers, contributed to building the confidence and motivation of carers to pursue their goals around work and care.

Partnership working was also important for CReate project staff to work with employers and contribute to creating carer-friendly workplaces. The case study of Renford (Chapter 6, Box 6.3) illustrates this. Initially, Patrick contacted Carers’ Resource regarding attending the event for employees. At the end of this event, Patrick and the CReate project manager discussed how they could work together to support carers in the workplace. Patrick also introduced the CReate project manager to his line manager, who had identified via an employee survey, that employees with caring responsibilities in this Renford site, did not feel supported in the workplace. Through developing these relationships, and after several months of organisation, the CReate project manager delivered the training for line managers at Renford. Observations and documentary analysis indicated that information packs handed out to line managers included information and leaflets from partner organisations regarding carers’ rights in the workplace. The presentation also drew on materials from other organisations and sources. The carers’ champion, introduced following the training, worked in partnership with a Carers’ Resource information officer and through this partnership, acted as an intermediary for employees with caring responsibilities at Renford.

Partnership working, in terms of mutualism and autonomy of an ethic of care, are important for understanding how the CReate project delivered person-centred support, contributed to creating carer-friendly workplaces, and promoted carers’ work-care reconciliation in practice. CReate project staff worked in partnership with internal and external partners and carers themselves to implement services. Recognising that we are dependent on each other and that agency develops through relationships were important for CReate project staff to promote carers’ work-care reconciliation. It was essential, however, for CReate project partnerships to be characterised by trust and reciprocity (also central to an ethic of care). The CReate project adviser trusted the organisations she referred Carol, Natasha, and Barbara to. She reported she had previously worked for the local business start-up voluntary organisation and still knew members of staff there. According to the CReate project manager, Carers’ Resource had a long-standing (over seven years) and positive working relationship with the Jobcentre adviser who visited the organisation regularly to provide benefits advice.

Trust and reciprocity within the Enterprise Club enabled carers to exchange ideas and develop an effective course of action regarding self-employment. As Lawrence stated when interviewed:

“Obviously we’ve freed up enough to talk about where we are, whether it’s problems that we’re facing or achievements that we feel we’ve made and I think it’s a good thing to have a talking-shop in a way where you can just bounce things around. And you can help each other as well, I certainly think that where you have a problem, if you have two or three people at least making some suggestions….. I’m not happy when anyone tries to be directive, but there’s nothing like that here, so I think it draws out of people what they need to do, so I think these groups are great”.

 (Lawrence)

It took time, however, to develop a relationship with some employers, such as Community Trust. The CReate project manager stated in discussion of partnerships using the eco-map:

 “(Community Trust) is a stronger relationship, that’s because they are part of our advisory group, but also, because we’ve been invited in to provide them with a carers policy and carers charter…. Definitely a stronger link, more activity”.

 (CReate project manager)

The relationship with Tradebank was re-kindled after several years:

But I picked up that link again, we had a meeting a couple of weeks ago, I was welcomed with opened arms, and we basically picked up from where we left off. There was full commitment from the Director of HR to be looking at supporting their members of staff who are carers.

 (CReate project manager)

Some CReate project partnerships were developed over several years. Partnerships also shifted and changed over the course of the project, and the degree they were characterised by trust and reciprocity. The CReate project, for example, initially ran a Work Club[[60]](#footnote-60) for carers in partnership with the Jobcentre, which aimed to provide a supportive and informal environment, in which carers could search for and apply for jobs. According to the CReate project manager, the Jobcentre initially provided £2000 for laptops and staff time. Carers’ Resource held the Work Club weekly in their offices, as a two-hour drop-in service, for up to eight carers. A CReate project adviser facilitated the sessions. The Jobcentre were to refer carers to the group. After two years of running the Work Club, however, the CReate project manager felt it was not beneficial for carers and the relationship with the Jobcentre became strained. This was due to a low number of referrals to the group and referral of inappropriate beneficiaries. Observations indicated that often only one or two people attended the groups, and sometimes none. Those referred were also often not carers, but those who had complex needs and were furthest from the labour market. In one Work Club observed, for example, there were three attendees; one disclosed he was an ex-offender and the other two reported having learning difficulties and health concerns. All were also over the age of fifty[[61]](#footnote-61).

Although there were some similarities with the support needs of carers, the CReate project manager felt the Jobcentre were referring difficult cases which required complex support. This is reflective of ‘creaming’ and ‘parking’, examined in Chapter 3, whereby organisations focus on those closest to the labour market more likely to achieve an ‘outcome’, and refer more complex cases to external organisations (Rees et al 2013b). The relationship between CReate project staff and Jobcentre staff became strained (indicated using the eco-map), and the CReate project ceased to deliver the Work Club. A breakdown in trust had a negative impact on the partnership between the CReate project and Jobcentre, and consequently, on support provided for carers. Partnership working, defined in terms of mutualism and autonomy of an ethic of care, is important for understanding the role of the CReate project in promoting carers’ work-care reconciliation. Partnership working was important for: generating referrals to the project; delivering person-centred support; working with employers to create carer-friendly workplaces; and developing the agency of carers, and employers, in relation to work and care. Trust and reciprocity (also central to an ethic of care), however, were important for CReate project staff to develop beneficial partnerships.

*Civil society and CReate project partnership working*

The forms, norms and space of civil society are conducive to partnership working, in line with an ethic of care, in practice. Some authors (Edwards 2011; Fukuyama 2001; Newton 2001), argue that civil society provides the space where people can come together in associational life. The norms of civil society, such as trust and reciprocity, are also fundamental for partnership working (Glasby and Dickinson 2008; Glendinning et al 2002; Sullivan and Skelcher 2002). Some previous research suggests that partnership working is important for understanding the role of voluntary organisations in work-care reconciliation (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011a; Formby and Yeandle 2005).

Voluntary organisations have worked in partnership to: influence employment policy and practice; influence national policy; deliver effective employment support for carers; provide carer breaks; support the health and well-being of carers; deliver training for carers; encourage people to recognise themselves as carers and generate referrals (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011a; Yeandle and Starr 2007; Formby and Yeandle 2005). Evidence from the CReate project indicated that partnership working, in terms of mutualism and autonomy, is important for understanding the role voluntary organisations can play in promoting carers’ work-care reconciliation. Evidence from the CReate project outlined here provides insight into how partnership working can promote carers’ work-care reconciliation, and some of the difficulties organisations can face working in partnership in practice. It demonstrates how the principles of an ethic of care, and the concept of civil society are important for understanding the role voluntary organisations can play in promoting carers’ work-care reconciliation.

## 7.4 Social inclusion

Social inclusion is the third major category important for understanding the role of the CReate project in work-care reconciliation. Social inclusion in the thesis is defined in relation to ‘inclusive diversity’ and ‘voice’ of an ethic of care[[62]](#footnote-62). Inclusive diversity refers to recognition that social identity affects the experiences of those delivering and receiving services (Williams 2002) and voice refers to the extent that beneficiaries of services can express their views regarding the organisation and delivery of services and the extent these are acted upon in practice (Williams 2002). Evidence from the CReate project indicates that promoting social inclusion (in terms of inclusive diversity and voice), was central to the design of the project. According to a member of Carers’ Resource development team, two consultation groups with carers (alongside one with partner organisations and an evaluation of a previous work-care reconciliation project), contributed to the design of the project:

“We had a series of questions and we had post-it notes and we asked the carers what kind of support they wanted, and we looked at what other organisations could offer. I gathered all the evaluation post-it-notes from the end of that meeting and put it all into a report. We thought that could provide evidence for a BIG Lottery funded project, so it was based on that, we put together our outline proposal”.

 (Carers’ Resource development team member)

And when the CReate project manager was asked when interviewed whether there was any input from external actors into the design of the project, she responded:

“Certainly from carers, because as with anything, when you’re setting something up you have to trial it out so probably carers weren’t actually that aware of it, we made carers aware this was a new project, we were trialling it, we always ask for feedback anyway, and it’s just been fortunate that with the CReate scheme, it’s evolved and I think it’s evolved because we’ve evolved it round the carers. So, we didn’t have paperwork and everything ready, as we were meeting with the carers, particularly the paperwork evolved, and as carers filled it in for us, we tweaked it and changed it”.

 (CReate project manager)

The voice of carers was important for the design of the project. CReate project staff also sought to be socially inclusive by targeting certain groups of carers, based on their socioeconomic or demographic characteristics. They prioritised contacting carers in the local Pakistani community because they knew their incidence of caring was high (ONS 2011) and that Pakistani women have very low employment rates, are likely to be living in low income households, and often face difficulty entering the labour market (see for example Turner and Wigfield 2013; Dale 2008; NAO 2008). Similarly, CReate project staff recognised that parent carers often face multiple barriers to labour market participation (see Fetton and Mearns 2012; Stiell et al 2006). As outlined in Chapters 5 and 6, 25% of carers who accessed the CReate project were Pakistani, in comparison with 18% of carers in Bradford, and 2% of carers in England. 35% of carers who accessed the project were parent carers. Observations and conversations with the CReate project manager indicated that she deliberately identified and contacted local parent carer groups and Asian women’s groups.

She contacted one local parent carer group, for example, and outlined the scope of the CReate project. They invited her to attend one of their fortnightly meetings, where she advised the carers of support available through Carers’ Resource, answered any questions and provided contact details for those who wished to access CReate services. Similarly, a CReate project adviser, who spoke several South Asian languages, attended a local Asian women’s network meeting. The adviser was invited to outline services available through CReate at the beginning of the meeting, indicated through observations, and for the remainder of the two-hour meeting, women were invited to speak confidentially with an adviser and to help themselves to leaflets regarding support available. CReate project staff were socially inclusive and engaged with specific groups of target carers. They also incorporated carers’ voice into the design of the project. Evidence from the CReate project indicates that the processes of social inclusion (voice and inclusive diversity), were important for delivering person-centred support and enabling carers to pursue their goals regarding work and care. The case study of Carol[[63]](#footnote-63) outlined in Box 7.3 demonstrates this.

Box 7.3 Case Study: Carol

Carol, aged 59, cares for her friend and housemate who has Autism. She has been a carer for 10 years and had not been in employment for 5 years due to mental health problems (unrelated to her caring responsibilities). A Jobcentre adviser referred her to the CReate project for extra support searching for jobs. Jobcentre staff did not identify her as a carer however and it was the CReate adviser who ran the Work Club (discussed in Section 7.3) who discovered through conversation that she had caring responsibilities.

Carol attended four one-to-one sessions with a CReate adviser. During her first appointment, she stated she had lost her confidence as she had become socially isolated and did not often leave the house. Carol reported she had received support for her health issues and felt ready and able to return to work. She was visibly very anxious. She stated she had previously worked as a health care assistant and care worker and wished to return to this line of work. The CReate adviser suggested they focus the first few sessions on confidence-building before searching and applying for jobs. Carol agreed.

Carol and the CReate adviser arranged to meet once a week. The CReate project adviser suggested small tasks to be completed in between sessions such as going to the shops and eventually, travelling to the next town on the bus, to widen Carol’s comfort zone. Tasks were developed in conjunction with Carol and the CReate adviser made it clear that it was not obligatory to complete tasks but encouraged her to do so. After a few weeks, Carol reported that she felt much more confident going out by herself and taking public transport and stated, ‘since coming here it’s been great because I’ve got the confidence back to actually go out and about and do stuff again’.

Following the advice of the CReate project adviser, Carol also attended the Beginner’s IT group and Managing Stress workshop and continued to attend the Work Club. She had a computer at home but stated beyond turning it on, she was unsure how to use programmes or the internet. Following the six-week IT course, she reported in conversation, and observations also indicated that, she felt able to use Word, send emails and search for job and volunteering activities. Having social interaction also contributed to building confidence, as well as developing specific skills.

Carol felt it was reassuring to know that other people are in the same position and found it helpful to share experiences and advice:

“So, it’s just a really good place to be, with people and things here. And the people that are coming, it’s like the lady says today, she had the same difficulty as me, which I didn’t know until they were saying there’s a stress management workshop, a two hour one and she says, we looked at each other and I went well I do and she went I need it too, because it’s so hard (to manage the stress of caring)”.

After three months engaging with the CReate project, the CReate adviser suggested that volunteering would be a good first step towards employment, but with less pressure. Carol agreed, and the CReate adviser enquired with other Carers’ Resource departments regarding potential volunteering opportunities available. The head of admin required some extra support filing and sorting documents. Carol volunteered with the admin team at Carers’ Resource, three hours a week, for six weeks. This allowed her to get back into a routine of going to work and built her confidence in a work setting, whilst being in a safe environment. She stated: ‘By volunteering, it’ll give me that opportunity to make sure I can do it, without going in feet first and end up being off (work) again’.

After five months of engaging with the CReate project, having regular meetings with an adviser, completing the Beginner’s IT course, and volunteering with the admin team, Carol started applying for jobs. She was offered a position as a care worker for 21 hours a week, which she felt was manageable with her caring responsibilities and her own health issues. She stated, ‘I couldn’t have gone to an interview without bursting into tears at the time because I wouldn’t speak to anybody so it shows what a big progress just coming here has made’.

Having access to services with the CReate project enabled Carol to work towards her goals regarding work and care. Carol’s participation in services, and having a voice, enabled the CReate adviser to deliver person-centred support. The CReate adviser shaped services around Carol’s support needs; Carol stated initially she had lost confidence, and the CReate adviser suggested they work together to build her confidence before applying for jobs. Although the CReate adviser made suggestions regarding activities and tasks she could pursue, Carol always agreed on these. Trust and reciprocity were important, however. Carol needed to trust the CReate adviser and had to commit to ongoing engagement with the CReate project. Carol appeared to feel at ease accessing Carers’ Resource services (*‘it’s just a really good place to be’*) and was also willing and able to engage with the project over several months.

The processes of social inclusion (voice and inclusive diversity), are also important for understanding the role of CReate project training and workshops in promoting carers’ work-care reconciliation. A case study of the pop-up shop[[64]](#footnote-64) outlined in Box 7.4 demonstrates this.

Box 7.4 Case Study: Pop-up shop

CReate project staff organised a pop-up shop, which ran for a week in Bradford city centre. A local voluntary organisation loaned the premises free of charge. According to the CReate project manager, the pop-up shop aimed to give carers experience of enterprise and self-employment. Several carers who accessed the CReate project reported in one-to-one sessions that they made items such as jewellery, soaps and candles, to have a break from caring, and were interested in potentially selling their items.

A CReate project adviser acknowledged this and developed the idea of running a pop-up shop. 25 carers in total participated and sold their items. A CReate project adviser delivered three training sessions for carers selling items, prior to the shop opening. These covered topics such as costing, labelling, and marketing. Observations indicated that carers in these sessions also provided each other with information and advice. Several carers involved in the pop-up shop had previous experience of selling their items at events such as craft fairs and shared their experiences with the group.

Several carers highly valued the experience and reported the pop-up shop had developed their skills and knowledge regarding enterprise. One carer interviewed, for example, stated:

“I had such a positive response to my work, and as well as selling it, I also earned some commissions. It really helped boost my confidence and so many of the people who were involved have gone on to do other things because of it, it’s been a wonderful catalyst. The experience of taking part in the pop-up shop was very powerful as I saw the impact it had on people when they were able to achieve something for themselves, they were making things themselves and selling them”.

 (Female carer)

Following the pop-up shop, CReate project staff held training sessions on selling items online, for carers who wished to pursue self-employment further. Again, carers with previous experience shared advice and made suggestions. A small group of carers reported in conversation they were planning to meet regularly, partly socially and partly to exchange ideas, information, and experiences, regarding selling their items.

Voice in relation to social inclusion in particular, is important for understanding how the pop-up shop promoted carers’ work-care reconciliation. The CReate adviser developed the idea of a pop-up shop based on carers’ interests. Carers’ exchange of expertise and ideas was also reflective of voice as sessions became carer-led. Promoting social inclusion was also important for supporting employers to create carer-friendly workplaces. Carers’ voice was important for encouraging line managers at Renford to improve support for carers in the workplace. Feedback forms following the training session indicated that the personal stories of carers and the CReate project manager’s own caring responsibilities, prompted many line managers to ‘think carer’. Contemporaneous observation also revealed that real-life examples clearly resonated with the audience.

Although the CReate project manager recounted case studies of carers, carers were not directly involved in designing or delivering CReate project training for line managers. This would have enabled carers to further have voice and could potentially have a significant impact on encouraging line managers to recognise the need to support carers in the workplace. The CReate project manager stated in conversation that they had previously considered involving carers, but had not yet pursued this further, as engaging with employers in the first instance had been challenging.

Reciprocity was important, however, for the CReate project to give carers voice and contribute to creating carer-friendly workplaces. For example, the Director of Carers’ Resource viewed the visit from the Princess Royal, as an opportunity to raise awareness with local employers of the importance of supporting carers in the workplace. This was with the view to spurn employers’ interest, and then provide further, ongoing, support, such as developing a carers’ policy or delivering training for line managers. The Carers’ Resource Director invited employers from a range of sectors (including health and social care, manufacturing, and electronics), to attend a networking lunch, followed by speeches from the Carers’ Resource development lead, and the Princess Royal. According to the CReate project manager, however, she invited all employers who attended to a follow-up lunch a few weeks later to discuss how they could work together to support carers in the workplace. No one attended.

Without employer engagement (reciprocity), the ability of the CReate project to contribute to creating carer-friendly workplaces, was limited. Carers’ Resource and CReate project staff, however, sought to give carers voice and raise awareness of the issues carers face in the workplace. Although this may not have resulted in practical changes in practice, raising awareness with employers is an essential prerequisite to creating carer-friendly workplaces (Yeandle et al 2002). Social inclusion, defined in terms of an ethic of care, is important for understanding the role of the CReate project in delivering person-centred support, contributing to creating carer-friendly workplaces, and promoting carers’ work-care reconciliation.

*Civil society and the role of the CReate project promoting social inclusion*

The forms, norms, and space of civil society are conducive to promoting social inclusion in relation to an ethic of care, in practice. Some (Anheier and Kendall 2002; HM Treasury 2002; Billis and Glennerster 1998) argue that voluntary organisations are able to engage with particular groups of beneficiaries as they are trusted, ‘closer’ to beneficiaries, and independent from the state and market. Some previous research indicates that voluntary organisations can promote the social inclusion of carers (Yeandle and Wigfield 2011a; Cook 2007). Voluntary organisations, for example, have been at the heart of the carers’ movement, which gives carers voice (Cook 2007). Evidence from previous research presented in Chapters 3 and 6 also indicates that voluntary organisations can be effective at engaging with particular groups of carers, such as BAME carers and parent carers who are often under-represented in services (Yeandle and Wigfield 2011a, 2011b; Formby and Yeandle 2005).

Evidence from the case study indicates that Carers’ Resource and CReate project staff worked in a socially inclusive way, and deliberately attempted to engage with carers often deemed at risk of social exclusion. The CReate project also gave carers voice in service delivery and when designing the project. Trust and reciprocity (norms of civil society) were important, however. Carers needed to trust CReate project staff to commit to engaging in services, and it was important for carers to trust each other to exchange knowledge and ideas. Social inclusion, as defined in terms of voice and inclusive diversity of an ethic of care, is important for understanding the role of the CReate project in promoting carers’ work-care reconciliation. Evidence from the CReate project outlined here provides unique insight into how voluntary organisations can work in a socially inclusive way to promote carers’ work-care reconciliation, and the difficulties that can arise.

## 7.5 Conclusion

The chapter examines the specific social processes and practices important for understanding the role of the CReate project in promoting carers’ work-care reconciliation and contributes to our theoretical understanding of the role voluntary organisations can play in promoting carers’ work-care reconciliation. Undertaking an in-depth, longitudinal, case study of a voluntary sector project delivering work-care reconciliation support, provides unique insight into how and why voluntary organisations can promote carers’ work-care reconciliation in practice. The chapter demonstrates that ‘policy implementation’, ‘partnership working’, and ‘social inclusion’, as defined in relation to an ethic of care, as well as trust and reciprocity, are important for understanding the role of the CReate project in work-care reconciliation. The forms (voluntary organisations), norms (such as trust and reciprocity), and space of civil society are conducive to policy implementation, partnership working and social inclusion in terms of an ethic of care, in practice. The following chapter examines the challenges to sustainability the CReate project faced, how these were negotiated over time, and the implications for the ability of voluntary organisations to promote carers’ work-care reconciliation.

# Chapter 8: Negotiating the sustainability of the CReate project

## 8.1 Introduction

Chapter 3 indicated that voluntary organisations studied, which have provided work-care reconciliation support, have often faced challenges to sustainability (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011a, 2011b; Yeandle and Starr 2007; Formby and Yeandle 2005). Chapters 6 and 7 demonstrated the role voluntary organisations can play in promoting carers’ work-care reconciliation, and how they can do so. The specific challenges to sustainability a voluntary organisation providing work-care reconciliation support faces, and how these are negotiated in practice, over time, however, remains under-researched. To address this gap in the literature, the chapter examines the main question:

* What are the challenges to sustainability that voluntary organisations providing work-care reconciliation support can face? and how can organisations negotiate these challenges in practice, over time?

The chapter examines the challenges to sustainability the CReate project faced, and how CReate project staff sought to achieve sustainability in practice, and with what success. The chapter analyses the implications of the challenges to sustainability, and ways these were negotiated in practice, for the role of the CReate project in promoting carers’ work-care reconciliation. It draws on interviews and conversations with CReate project and Carers’ Resource staff, ongoing observation of CReate project activities, interviews with key partner organisations, and documentary analysis of the CReate project evaluation and Carers’ Resource funding bids.

The chapter is organised as follows. Section 8.2 identifies the principal challenges to sustainability the CReate project faced, and the significance of these challenges for the role of voluntary organisations in promoting carers’ work-care reconciliation. It interprets the challenges faced using the concepts ‘securing funding’, ‘recruiting and retaining staff’, and ‘demonstrating impact’, considered in Chapter 3. Section 8.3 examines how Carers’ Resource and CReate project staff negotiated sustainability in practice, and the implications for the role of the CReate project in promoting carers’ work-care reconciliation. It suggests that the ways CReate project staff negotiated these challenges can be understood as, ‘delivering publicly-funded services’ and ‘strategic decoupling’, also examined in Chapter 3. Section 8.4 outlines the extent Carers’ Resource staff achieved sustainability and Section 8.5 summarises the principal arguments of the chapter.

## 8.2 Challenges to sustainability: securing funding, demonstrating impact and recruiting and retaining staff

Sustainability is defined in the thesis as a dynamic social process and includes both economic and social sustainability. It refers to the ability of voluntary organisations to ensure financial security to maintain service delivery and the capacity of organisations to promote the principles of social sustainability; human well-being, equality, democratic governance and democratic civil society (see Chapter 3, 3.6 for full discussion) (Dillard et al 2009; Magis and Shinn 2009; McKenzie 2004). Evidence from Carers’ Resource and the CReate project suggests that CReate project staff faced three main challenges to sustainability; ‘securing funding’, ‘demonstrating impact’ and ‘recruiting and retaining staff’.

*Securing funding*

Securing funding was one of the main challenges to sustainability the CReate project faced, and all CReate project staff identified securing funding as a central issue. One CReate project adviser stated, “well I mean obviously the main challenge is funding*”.* BIG Lottery funded the project for three years (Carers’ Resource 2012). The Director of Carers’ Resource indicated when interviewed that, as an organisation, they receive little funding from individuals and rely heavily on procuring grants and contracts to deliver services. The ability to identify and attain funding was essential for the sustainability of the CReate project. Although applying for an extension to BIG Lottery funding was always an option, the CReate project manager stated in conversation, she did not want to presume their bid would be successful or, ‘place all their eggs in one basket’. Interviews and observations indicated that the Director of Carers’ Resource, CReate project manager, and trustees (who were responsible for ensuring sustainability), were concerned with, and worked towards, financial security throughout the project. One of the trustees stated when interviewed:

“As soon as you get a contract like that [CReate project BIG Lottery fund contract] and you know it’s time limited, part of the horizon-scanning will be where would we go next so that we can continue to provide the service. Since 1999 we’ve been able to provide a broadly similar service continually but from lots of different sources of funding, so we will continue to look for lots of different sources of funding because we think there is a value to this (supporting carers to combine work and care)”.

                                                                            (Trustee, Carers’ Resource)

Carers’ Resource staff aimed to maintain a service to tackle the issue of work-care reconciliation as they recognised it was important for carers and gain a further tranche of funding. Carers’ Resource staff felt, however, that options regarding funding were limited. The Director of Carers’ Resource expressed frustration at the lack of funding available through the local authority for work-care reconciliation support, and felt it was important to persuade commissioners that voluntary organisations could be well-placed to deliver this support:

“I’m interested in what did happen to the money that the government ultimately put into the DWP?[[65]](#footnote-65) We could have done that. That money used in small amounts across the carers centres, we could have done it. Instead of which, my instinct and our evidence would show, most carers with employment difficulties, either seeking employment or staying in employment do not go to a Jobcentre, this is the truth of it”.

                                                                           (Director, Carers’ Resource)

BMDC (Bradford Metropolitan District Council) did not fund local voluntary organisations to provide these services[[66]](#footnote-66). A BMDC member of staff interviewed, felt it was the responsibility of the DWP to fund work-care reconciliation support, not the health and social care department, which funded other carer services in Bradford, including services delivered by Carers’ Resource:

“There’s nothing about employment in there, in the formal contract, in the Integrated Carers’ Service[[67]](#footnote-67) contract. I’m a bit of a mind that employment is more to do with the DWP than it is to do with social care, and so we didn’t build a specific employment responsibility into the contract. But I guess what I have done and what I’m prepared to do is to work with Carers’ Resource because we know that employment is important, it’s an important issue for carers, so how do we work with them to bring in other funding sources to do other elements of work to support the overall offer for carers in the district, beyond what we’ve commissioned in health and social care”.

                                                             (BMDC local authority employee)

According to one of the trustees, they could use reserves for a ‘limited amount of time’ to ensure provision of work-care reconciliation support:

It could quite literally be, you’re walking along in a straight line and you drop suddenly down onto a new level, as trustees we’ve been quite clear that where there is a strong justification for it, we would smooth that into a slope rather than a cliff-edge and use some of our reserves to manage that process more smoothly and there are certain activities which are so fundamental to our collective vision of what we were set up to do that we would pay for them from reserves for a limited amount of time.

 (Trustee, Carers’ Resource)

The trustee clarified that work-care reconciliation support would be included within the organisation’s ‘fundamental activities’. They could not use reserves, however, for long-term financial sustainability. Although Carers’ Resource have delivered work-care reconciliation support in some form since 1997 (see Chapter 5), the capacity of Carers’ Resource staff to support carers to combine work and care or return to work would be limited without further funding. Prior to gaining BIG Lottery funding for the CReate project, information team staff provided employment support, although this was beyond their contractual obligations. According to a member of staff who delivered these services, however, the limited resources in terms of personnel and time, limited the number of carers they could engage with and support. Voluntary organisations are finding it increasingly difficult to procure funding within an increasingly competitive environment (Macmillan 2010) and funding was an issue identified in previous research regarding the role of voluntary organisations in promoting carers’ work-care reconciliation (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011b; Formby and Yeandle 2005). Securing funding was one of the principal challenges faced by Carers’ Resource and CReate project staff and was essential for both the financial and social sustainability of the project, and the ability of the project to promote carers’ work-care reconciliation. Without funding, Carers’ Resource would be unable to remunerate staff, who were essential for delivering services.

*Demonstrating Impact*

Demonstrating impact was another challenge to sustainability CReate project staff faced. Carers’ Resource and CReate project staff emphasised, when interviewed, the importance of collating evidence to ensure financial sustainability:

“I have been absolutely committed to gathering evidence. Nowadays the language is all about producing outcomes, well we were collecting all the evidence in the mid-1990s and forward, of what impact having specialist carer workers was having in the field, which in today’s language is evidence of outcomes as well as outputs, but the idea of real-time evidence has stood us in good stead, that’s been a technique that’s been very useful, that, and gathering carer’s stories”.

 (Director, Carers’ Resource)

“It’s about targets and demonstrating a good return on investment for whoever it is that’s funding, so we’ve got to make sure that the paperwork is right, we’ve got to make sure that there’s a firm evidence base, that we’re measuring distance travelled and social impact, not just when we’re evaluating the efficacy of our projects, but also when we’re tendering for new projects and putting in funding bids for new projects. It’s really important that we not just deliver a quality service, but we capture that information so that we can feed that back to our funders”.

(CReate project adviser 1)

Demonstrating the impact of the project was important for securing future funding. A Carers’ Resource development team member reported that the project evaluation report formed a central component of the application for an extension to BIG Lottery funding. The BIG Lottery Fund required a yearly progress report outlining the number and characteristics of carers who accessed services and reported outcomes. A six-monthly telephone report was also required and a final evaluation report when funding came to an end, as stipulated in the initial bid for funding (Carers’ Resource 2012). Carers’ Resource and CReate project staff faced several barriers to demonstrating impact as: evaluation tools were often not used in practice; staff did not have sufficient resources to deliver services and monitor progress regularly; there were issues with recording and organising data; and the nature of the services made it difficult to demonstrate impact (see Chapter 4, Section 4.5 for overview of issues regarding collecting and collating monitoring data). In practice, gathering evidence and demonstrating impact became less of a priority over the duration of the project. Staff turnover became an issue six months into the project, and, according to the CReate project manager, maintaining service delivery and generating referrals to the project was of higher priority than monitoring and evaluation.

CReate project staff also reported they felt there was too much paperwork for themselves and carers to fill in, particularly when they were also delivering National Careers Service services, examined further in Section 8.3. Some carers commented negatively during one-to-one appointments observed about the amount of paperwork required. The CReate project manager reported that the initial return rate of evaluation forms, prior to the data collection period, was very low. Initially, a CReate adviser sent forms by post to carers when their engagement with the project ended. According to the CReate project adviser who had sent them, two out of approximately thirty forms, were returned. Consequently, the CReate project manager did not feel they were effective at gaining feedback and demonstrating impact. CReate project staff interviewed were not aware of the evaluation form initially used and stated the CReate project manager had not instructed them to send it to carers.

CReate project staff also indicated it was often difficult to determine a clear end to carers’ engagement with the project. Observations demonstrated that carers often accessed and required services sporadically, often with a gap of several months in between appointments. Many carers also attended one or two appointments and subsequently did not respond when CReate project staff attempted to contact them. According to the CReate project manager, this was often when carers did not feel ready or able to fully engage. Consequently, there was often no discernible ‘end’ to carers’ engagement with the CReate project at which to collect evaluation data. Furthermore, CReate project staff felt it was difficult to evidence the impact of the work they did as it was not ‘quantifiable’:

“When you’re putting these programmes together, all organisations are under pressure from governments to deliver whatever government wants but I think that the things that are important, certainly from my perspective, are not quantifiable and they don’t sit easily on a report, you know, on something that you can tick a box with”.

 (CReate project adviser 2)

Storing and recording data was also an issue. As outlined in Chapter 4, staff used various means to collate monitoring data and consequently, observations indicated that CReate project staff found it difficult to collate the required information for on-going BIG Lottery monitoring. The introduction of the new organisation-wide database also resulted in some ‘teething’ issues and the details initially collected regarding carers were streamlined. CReate project staff reported that prior to the introduction of the database, data regarding beneficiaries were not uploaded due to time restrictions and most records were kept on paper. As a result, CReate project staff reported it was difficult to collate the necessary information for the final evaluation of the project. The BIG Lottery fund required data regarding the number and characteristics of carers who accessed the project, data regarding the outcomes achieved in accordance with the targets outlined in the initial bid for funding, and evidence of how they achieved these outcomes. According to a member of Carers’ Resource development team, they could demonstrate the impact of the project as they saw fit. The BIG Lottery grant manager provided some advice regarding the layout of the evaluation and the elements considered most important. He also directed CReate project staff to the BIG Lottery website for guidelines for on carrying out and writing evaluations.

Observations indicated it took considerable time for CReate project staff to collate all necessary information. The CReate project manager assumed that all monitoring information required was readily available, whereas CReate project staff reported they were not asked to collect all the information required for the evaluation. The CReate project manager appointed a volunteer with extensive research experience to collate the necessary information[[68]](#footnote-68), to be supplied to him by the CReate project advisers. A member of the Carers’ Resource development team would then write the evaluation report. The volunteer reported he found it difficult, however, to collate the quantitative data required, as he was unfamiliar with Carers’ Resource monitoring systems and the CReate project’s services.

Carers’ Resource and CReate project staff also felt that case studies of carers who had accessed the project, qualitative data, were the most valuable in terms of demonstrating impact. Although Carers’ Resource recognised the benefits of demonstrating impact and have always attempted to collate evidence regarding their projects, CReate project staff faced several barriers to demonstrating impact in practice. Service delivery was priority for CReate project staff, and evidence suggests that a lack of communication between the CReate project manager and CReate project staff, resulted in evaluation forms not being sent and monitoring information being recorded in diverse ways by different members of staff.

As voluntary organisations are playing a greater role in society and delivering public services, they face greater scrutiny and are expected to demonstrate their impact, both in terms of value for money and social value (Teasdale et al 2012). At the same time, there has been a drive for increased impact measurement from within the voluntary sector itself (Harlock 2013; Lumley et al 2011; NPC 2010; Fyfe 2005; Anheier and Kendall 2002). Voluntary organisations often face barriers to demonstrating impact, however, including: insufficient resources; inadequate skills; and demanding targets and data collection requirements of different funders (Arvidson and Kara 2014; Ogaìn et al 2012; Ellis and Gregory 2008).

CReate project staff did not have sufficient resources to deliver services and develop effective monitoring systems during periods of high staff turnover. Staff turnover also resulted in monitoring data being recorded in various places by different members of staff which made it difficult to collate. Evidence from the CReate project suggests that CReate project staff faced barriers to evaluating and demonstrating the impact of the project, which was essential for the financial security of the project.

*Recruiting and retaining staff*

Recruiting and retaining staff was another challenge to sustainability the CReate project faced. Chapters 6 and 7 demonstrated that recruiting staff with appropriate skills and expertise was essential for promoting carers’ work-care reconciliation. Seven CReate advisers delivered the project over its duration. Five CReate advisers appointed left the organisation. At the beginning of the project (and prior to the period of data collection for the thesis), the CReate project manager reported that Carers’ Resource already employed herself and one adviser. They both also had experience delivering work-care reconciliation support projects. Carers’ Resource appointed a second adviser who had relevant experience, and excelled in the role, however, she had to move out of the area. Another adviser was subsequently appointed, but only stayed in post for four months as he felt the role was ‘not for him’.

The CReate project manager reported Carers’ Resource advertised for a new adviser in local newspapers, on the Carers’ Resource website, in the Carers’ Resource newsletter and within their networks in the local area. They used these methods as they did not incur any expense. According to the CReate project manager, however, these recruitment methods did not yield high numbers of applicants (only six applied for the position), and those that did apply did not have all required skills and expertise. As a result, they extended the recruitment period and only one adviser delivered CReate services for three months. Eventually they appointed an adviser with previous employment support experience. After his six-month probationary period, however, the CReate project manager reported she reviewed his progress and did not feel he had been performing as expected in the role. Consequently, Carers’ Resource did not extend his contract.

Shortly after, the other CReate adviser handed in her resignation. She reported she had found working with the previous colleague extremely stressful and needed a change. This led to a three month ‘hiatus’ in the project whilst they recruited new members of staff. The CReate project manager agreed this with the BIG Lottery Grant Manager. Data collection for the thesis commenced following this gap in services after they appointed new CReate advisers. Following initial issues with recruitment, the CReate project manager decided to advertise the CReate project adviser positions with large recruitment agencies. She reported that although this did yield a much greater response in terms of quantity of applicants, she did not feel the quality of applicants had improved in terms of their relevant experience and skills. Advertising with large agencies also incurred significant costs for Carers’ Resource.

Carers’ Resource staff involved in the recruitment process and the CReate project manager also disagreed regarding which candidates to appoint, as they had different priorities regarding the desired skills and qualities of members of staff. Some placed greater significance on identification with the core values of the organisation, whereas others deemed employment support expertise and formal qualifications more important. After much deliberation, they recruited two new members of staff who they felt had the right balance of expertise and values in line with the organisation. Yet, after three months of service delivery, observations indicated that disagreements arose between the two advisers over role boundaries. According to conversations with the CReate project advisers, a lack of clear job roles caused tension as there was significant overlap between roles. Whilst one adviser focused on workshops and training and one on the one-to-one support, they provided both these services as and when needed. One adviser expressed frustration as they did not feel the other was sufficiently contributing to service delivery. The relationship between the advisers became strained and following one dispute, one of the advisers resigned due to ‘irreconcilable differences’ as the CReate project manager described it.

Although another adviser was appointed, towards the end of funding she took up another position due to financial insecurity and uncertainty. She stated when interviewed:

“As long as I’ve worked here really, I‘ve never known if I’m going to have a job after this time next year and that does mean you’re looking around all the time you know, if I saw something else, I don’t want to go, but I’d perhaps be sensible to consider going because obviously my job’s not safe and I need to pay my mortgage and all of that and I suppose, the change in governments, the change in priorities, that’s going to be a fact of life, and Carers’ Resource has been really good at keeping projects going sometimes on a shoestring, but you can’t work for nothing and it’s a very difficult message to give to carers as well”.

                                                                                       (CReate adviser 1)

Issues regarding staff recruitment and retention had a significant impact regarding CReate project service delivery and the sustainability of the project. Although Carers’ Resource staff and the CReate project manager endeavoured to ensure minimal disruption for carers, high staff turnover inevitably had an impact on service delivery. Observations indicated that several carers who accessed the project prior to the three-month hiatus did not return when new members of staff had been appointed. As one CReate project adviser stated when interviewed, it took considerable time for new members of staff to build partnerships to deliver services:

“Obviously the people go because they’ve got to still earn a living and when you’ve spent five years building a service all of that knowledge goes too. So even if you put somebody new in post, you’ve then got all of that time it takes to build those contacts and build that awareness and make mistakes and all that sort of thing so there is something to be said for continuity”.

                                                                            (CReate project adviser 1)

Partnerships with other organisations also deteriorated as a result of high staff turnover. A Jobcentre adviser stated when interviewed:

“We left it with a consultancy basis and that’s the same with a lot of organisations, if you’re not in somebody’s face, you’re not seeing a physical person then they tend to forget about that service”.

                                                                                       (Jobcentre adviser)

The Jobcentre adviser implied that due to a period of high staff turnover, CReate project staff were not regularly attending Jobcentre Plus meetings and so were not at the forefront of organisations they would refer people to. High staff turnover impeded service delivery and partnership working, which, as demonstrated in Chapter 7, was essential for promoting carers’ work-care reconciliation. Staff recruitment and retention presented a considerable challenge to the social sustainability of the project and its ability to provide appropriate work-care reconciliation support and promote the well-being of carers. High staff turnover also impacted service delivery and consequently, the ability of CReate project staff to meet the BIG Lottery funding targets.

As employment contracts with voluntary organisations are increasingly short-term and precarious, voluntary organisations have been finding it increasingly difficult to recruit and retain valuable members of staff (AGCC 2014; Cunningham et al 2013; Buckingham 2009; Nickson et al 2008; Cunningham and James 2007; Wilding et al 2004). Some voluntary organisations providing work-care reconciliation support also faced difficulty retaining key staff members (Wigfield and Marangozov 2014) or recruiting staff in the first place (Yeandle and Wigfield 2011b). Evidence from the CReate project indicates that one member of staff sought alternative employment due to the precarious nature of the role. Potential candidates may also have been discouraged from applying due to the short-term nature of contracts. CReate project staff raised in conversation that they also felt the job description was too vague and did not adequately reflect the role. They felt that this would deter potential applicants. Whilst voluntary organisations sometimes face difficulty recruiting staff if role descriptions are too specific (AGCC 2014), in this case, it was felt the job description was too vague.

Some members of staff also had a lack of ‘job embeddedness’. Job embeddedness refers to a range of factors which can be used to predict employee retention, including: links, fit and sacrifice between an employee and organisations and links, fit and sacrifice between an employee and the community (Halbesleben and Wheeler 2008; Holtom et al 2006; Mitchell et al 2001). Those who have stronger ties with the organisation they are employed by, and the community in which they work, are deemed less likely to leave their job. ‘Links’ refer to the personal relationships an employee has with others in the organisation and the community in which they are working. ‘Fit’ relates to the perceived fit within an organisation and community and includes aspects such as whether they feel they are using their skill set, and opportunities for training and development. Sacrifice refers to the perceived losses associated with leaving a role. One staff member, for example, had moved to the area due to family reasons and did not have strong links with the community. As they also had a disagreement with another CReate project member of staff, they had low levels of job embeddedness. The short-term nature of the job contract (1 year or 6 months) also meant that the perceived losses associated with leaving were low. Although increasing insecurity within the voluntary sector was a factor in relation to staff recruitment and retention, job embeddedness was also important. With increased uncertainty and competitiveness within the voluntary sector, job embeddedness may decrease and result in further difficulties regarding the recruitment and retention of staff in voluntary organisations.

Recruiting and retaining staff was a challenge to the social and financial sustainability of the project. Staff with appropriate skills were essential for promoting the well-being of carers and high staff turnover impacted the ability of the project to deliver services and meet its targets, which could have affected Carers’ Resource’ prospects of securing future funding[[69]](#footnote-69). Chapter 6 demonstrated that dedicated staff were essential for delivering person-centred support and supporting employers to create carer-friendly workplaces. Chapter 7 indicated that competent staff were essential for promoting carers’ work-care reconciliation. Without a workforce with appropriate skills, the ability of the CReate project to promote carers’ work-care reconciliation would be significantly restricted. Evidence from the CReate project indicates that securing funding, demonstrating impact, and recruiting and retaining staff were three considerable challenges to sustainability faced during the project.

## 8.3 Negotiating sustainability: delivering publicly-funded services and strategic decoupling

*Delivering publicly-funded services*

Delivering publicly-funded services was one of the principal ways Carers’ Resource staff sought to ensure the (financial) sustainability of the CReate project. During the second year of the project, Carers’ Resource bid to deliver National Careers Service (NCS) employment support services in Bradford. Carers’ Resource management, including the CReate project manager indicated they felt delivering NCS services would ensure the financial sustainability of the project, as CReate project staff in Harrogate were already delivering NCS services and received the majority of their funding from NCS. The bid was successful and CReate project staff began delivering NCS services alongside BIG Lottery-funded services. According to the NCS contract, 120 clients had to access services over a year (NCS 2015). Payment was by results; they received £10 for the first appointment (CV analysis) and £30 for subsequent appointments. £1000 was received if someone entered employment or learning, defined by NCS as ‘full-time employment or learning for at least 13 continuous weeks’ (NCS 2015).

Clients were only able to attend three one-hour appointments with an adviser. The client base stipulated in the contract included people aged over 50, ex-offenders, and people with learning difficulties, as well as carers. CReate project staff diversified their clientele. Voluntary organisations have increasingly been diversifying their client-base to adapt to funding contracts and ensure financial sustainability (Arvidson 2009). In practice, CReate project staff felt that the terms of the NCS contract greatly restricted their ability to support carers:

“The main challenge has been delivering what people need with the funding constraints that we have so working in the way that we feel is beneficial to carers with the limitations of what we’re funded to do, that’s the main difficulty”.

                                                                                  (CReate adviser 3)

“There are a number of other services out there that would perhaps allow for the continuation of the service that we provide in an ever so slightly modified service, such as the National Careers Service, which unfortunately would limit the amount of interactions that we have with people. And, unlike other people who may be job-ready but may have one or two issues that need to be ironed out, oftentimes, carers need a bit more on-going assistance, perhaps they were out of employment for a long period of time, a long history of, oftentimes for 10 years or so, so they often need slightly more support than could be provided in three sessions as generally the National Careers Service allows”.

 (CReate project adviser 2)

Although clients were only entitled to three appointments with NCS services, CReate project staff continued to provide on-going support for carers. In Harrogate, CReate project staff delivered any additional support required unfunded. In Bradford, carers could continue to access CReate project support provided with BIG Lottery funding. CReate project staff did not view NCS funding as a feasible way to ensure sustainability, due to its demanding contractual obligations:

“It’s a very difficult contract to deliver and we’re not 100 per cent confident that we will maintain contract compliance. They’ve given us very difficult targets, they’ve asked us to focus on the clients furthest away from the labour market, and the funding model really is about generating hard outcomes in terms of sustainable learning or jobs. We don’t necessarily see a long-term future in the NCS, it’s just getting more and more difficult for us as an organisation”.

 (CReate adviser 3)

Whilst management were keen to pursue NCS contracts in Bradford to ensure a base level of income, CReate project staff felt contracts were too insecure, and services not suitable for carers. Furthermore, a condition for future NCS contracts was that all staff delivering services had to hold, or be working towards, completing an NVQ Level 2 in employment support. Carers’ Resource would have to pay for the CReate advisers to gain this qualification. The two advisers in Harrogate already held this qualification, but those in Bradford did not. Carers’ Resource management offered to finance the two advisers to complete the course under the condition that they remained with the organisation to deliver NCS services for a minimum of two years, or they would have to repay the fee themselves. Both CReate advisers declined. They both reported they were not able to commit to two years and did not wish to deliver NCS services. They felt the contract was difficult to deliver, had unrealistic targets, and the client base was too diverse. CReate project staff delivered NCS services as required under the initial contract and Carers’ Resource did not seek to renew it.

CReate project staff delivered publicly-funded services to ensure the financial sustainability of the project. Staff raised concerns, however, regarding the sustainability of the project delivering NCS services, and did not feel that the funding enabled them to adequately support carers. Delivering NCS services also resulted in ‘mission drift’, examined in Chapter 3, whereby voluntary organisations diversify their clientele, or aims, to adapt to the funding environment (Arvidson 2009). Mission drift is becoming an increasing issue with shifts away from grant funding to contracts and voluntary organisations delivering public services (Macmillan 2010; Arvidson 2009; Shared Intelligence 2009; Rees 2008; Charity Commission 2007; Alcock et al 2004). With the NCS contract, carers were no longer the core client group. Chapter 6 and previous research indicates that carers often need long-term, ongoing support (Wigfield and Marangozov 2014), whereas only three appointments were available under the NCS contract. Carers also often need support with factors such as building confidence (Formby and Yeandle 2005) (see also Chapter 6) prior to returning to work, whereas NCS services focused on practical aspects of searching and applying for jobs. Delivering NCS contracts after BIG Lottery funding ceased would have limited the ability of staff to promote carers’ work-care reconciliation and support carers in achieving their aims.

Furthermore, delivering publicly-funded services is often associated with the erosion of the values of civil society, such as trust and reciprocity (Civil Exchange 2016; The Baring Foundation 2014, 2013; Aiken and Bode 2009; Carmel and Harlock 2008), which, as Chapter 7 indicated, enabled CReate project staff to implement policy in line with an ethic of care, work in partnership and promote social inclusion; processes important for promoting carers’ work-care reconciliation. People often trust voluntary organisations over others as they are independent from the state and do not seek to generate profit (Weisbrod 1988; Hansmann 1980). Delivering publicly-funded services reduces the independence of voluntary organisations (Cairns et al 2010). The design of NCS services was also not in line with an ethic of care, which Chapter 7 demonstrated was essential for work-care reconciliation. Carers’ Resource staff did not recognise and take responsibility for providing support, but were obliged to deliver services, whereas, in accordance with an ethic of care, it is important to wantto provide support. In relation to competence, services were also not appropriate to support carers who often require on-going, person-centred support. If staff had decided to continue to deliver this contract, it could have had significant implications for the ability of the CReate project to promote carers’ work-care reconciliation.

The sustainability of the CReate project was also dependent upon the financial security of the Carers’ Resource and the Carers’ Resource office in Bradford in particular. The majority of Carers’ Resource funding was received through contracts with local authorities. The Bradford office was established in 2010 when Carers’ Resource was successful in its bid to deliver information services and emergency planning for carers for BMDC (Bradford Metropolitan District Council) (see Chapter 5, Section 5.2). This contract came up for tender half way through CReate project funding. If Carers’ Resource were unsuccessful in renewing the contract, the CReate project would have to move premises and would not be able to refer to the information and casework teams for advice. Furthermore, the majority of referrals to the CReate project were generated through the information and casework teams and their contacts with GPs and social care in the area. According to the Director of Carers’ Resource, BMDC altered the contract when it went out for tender and the new contract stipulated that one organisation would deliver what BMDC termed ‘Integrated Carer Services’ for the whole district. Previously, services for carers funded by the local authority were delivered by three different voluntary organisations (one of which was Carers’ Resource).

Although Carers’ Resource bid was successful, a local authority employee interviewed reported it had been very close between Carers’ Resource and a national organisation which guaranteed to deliver services at a lower rate. According to the Director of Carers’ Resource, the reason Carers’ Resource were awarded the contract was due to an innovative approach to commissioning introduced in Bradford. A local authority commissioner established a carer’s forum which played a significant role in the bidding process. 60% of marks were received for the written application, 20% for an interview with a panel of seven from the statutory sector and 20% for an interview with a panel of carers. According to a local authority employee, the scores were very close between the Carers’ Resource and the national organisation however the carer’s forum agreed unanimously that Carers’ Resource should be awarded the contract:

“A panel of people drawn from the NHS and local authority, make a judgement as to which one they think is the best way of doing it (delivering services for carers) and that combined with the price is how we make a judgement as to who gets the contract. What we have with the Integrated Carers Service was a carers panel as well who made up their own questions…..it will become folklore I guess, because carers actually made the call. The scores that professionals had come up with were so very very close, actually it was really down to the carers choice who was going to provide the service in Bradford, which was incredibly enlightening, but a bit scary”.

                                                                   (Local authority employee)

The carer’s forum ultimately determined the outcome of the bidding process. In this case, the views of carers had a significant impact on commissioning, as well as the price of services. This is contrary to many other cases and reports of voluntary organisations being ‘priced-out’ by larger private and public-sector organisations (Damm 2014; Lane et al 2013; Rees et al 2013; Macmillan 2010; Buckingham 2009). The Director of Carers’ Resource felt BMDC commissioners had a good relationship with voluntary organisations and listened to the needs of carers:

“It’s the enlightened thinking for me, the fact that Bradford is used to working with the voluntary sector, it likes to be inclusive, there are other local authorities not a million miles from here who use the monies to create more posts in-house. I have valued the fact that Bradford has been inclusive, it’s got close to its carer client-base and carers were involved in helping to draw up the spec, which is another example of really good practice. And it isn’t that the ICS was drawn up entirely by talking with us and we had the two major contracts, it was that they listened to carers, they listened to other stakeholders, it was a truly inclusive exercise and to come up with an integrated model like that I think is really leading-edge, so I’m very proud we got it”.

                                                                       (Carers’ Resource Director)

Carers’ Resource procured the contract to deliver Integrated Carer Services in Bradford for three years, with the potential to extend the contract. According to the Director, this would ensure the financial sustainability of Carers’ Resource in Bradford. Delivering this public service contract, however, had a number of implications for Carers’ Resource including: an acquisition of staff; restrictions to services; and tension with partner organisations. As the Integrated Carers Service was to be delivered by one organisation only, a small local voluntary organisation that provided support for carers lost its funding. This organisation provided activities and trips for carers which were not funded within the new contract. Some staff from this other organisation accepted positions within Carers’ Resource caseworker team, made available through the new funding. According to the Carers’ Resource Director, staff from this organisation were prioritised in terms of recruitment, however, not all wished to transfer and not all staff were able to be kept on by Carers’ Resource.

This caused some initial tensions between staff who transferred and Carers’ Resource staff. The Director indicated that there had also previously been some rivalry between the two organisations, as they often bid for the same funding. Staff from the smaller organisation indicated they were not familiar working to such strict targets and felt there was a different ‘feel’ to Carers’ Resource than their previous organisation. Evidence from previous research indicates that mergers in the voluntary sector are often difficult to achieve, due to organisational culture (Rees et al 2012). Although the smaller organisation did not ‘merge’ with Carers’ Resource in the traditional sense, Carers’ Resource essentially acquired their staff and the smaller organisation ceased to deliver services. After a few months, however, the head of the caseworker team reported that all staff who had transferred had fully integrated and any initial tensions had been resolved.

Delivering the Integrated Carer Services contract also resulted in a shift in the services delivered. Some services, such as groups and trips which Carers’ Resource delivered were not funded through the new contract:

“So they bundled it all up into this £1 million contract which looked huge, but not many people did what I did which was go through the very small print and in actual fact it hardly covers the costs of all the component bits and the added blow which was unfortunate was that the activities project which was separately funded, so the Something Good that (Carers’ Resource staff member) did and there’s some monies that (Carers’ Resource staff member) had previously to provide taster sessions for trying out care provision. They stopped. Our Caring Confidently stopped which was a training programme, those all stopped unfortunately. And there are those who think that with £1 million, why aren’t we carrying on providing all of that? who didn’t look at the fine print and realise that the core services that were transferred under that core contract more than made up for the amount of money that we were being given”.

     (Carers’ Resource Director)

The contract signified a shift away from social activities and trips for carers to take a break from their caring role, to delivering practical services to support carers in their caring role. The services included under the new contract included Emergency Planning (putting a contingency plan in place if something happens to the carer or they are unable to provide care) and providing information regarding any aspect of caring and undertaking carer’s assessments. According to CReate project adviser 2, Carers’ Resource received complaints from carers who had previously accessed groups and trips provided by the small voluntary organisation, as these services were no longer available. As this other organisation was based in the city centre of Bradford, carers also had to travel further to access services. From a resource dependence perspective, organisations will adapt according to their environment to secure resources (Pfeffer and Salancik 2003). As stated previously, however, this can result in mission drift, and a shift away from a voluntary organisation’s core objectives, towards those of the funder (Arvidson 2009). The Director of Carers’ Resource felt that services were becoming increasingly restricted by outcomes stipulated by the funder, although they still endeavoured to maintain a carer-centred focus:

“That has become more difficult as years have rolled by because as the statutory sector becomes more prescriptive in the way it contracts with the voluntary sector you end up being rather more constrained into the data that the commissioner wants but our philosophy is to be client-focused. And quite often we know more about what is done than the contract says”.

 (Director, Carers’ Resource)

The casework manager reported in conversation that they had experienced difficulty delivering the new contract in the first year due to strict targets. Increased competition for contracts in the area also had a negative impact on relationships between voluntary organisations in the area. Conversation following observation of an Integrated Care meeting at a local GP practice (which aimed to determine how organisations could work together to provide support for some of the most difficult patients), between health and social care staff and representatives from voluntary organisations in the area, indicated that partnership working had deteriorated due to increased competition for funding locally. Representatives from voluntary organisations appeared to attempt to ‘out-do’ each other in terms of the support they could provide, and a sense of competition was palpable. Conversation with one representative from a local voluntary organisation following the meeting indicated that several of the organisations present worked on similar issues, however, no longer shared ideas and information as they had become rivals for funding. Evidence from the CReate project reflects some previous research that with increased competition for funding, there is a decrease in trust between voluntary organisations (Rees et al 2013). Partnership working and relationships based on trust were important for the role of the CReate project in promoting carers’ work-care reconciliation (see Chapter 7, 7.4).

Carers’ Resource staff bid for and delivered publicly-funded services, to ensure the financial sustainability of the organisation. As the CReate project was situated within Carers’ Resource, the sustainability of Carers’ Resource was essential for the sustainability of the project also. Evidence from the case study suggests that because of delivering the Integrated Carers Contract, there may have been some erosion of trust with carers who had previously accessed services which were no longer available. Although Carers’ Resource endeavoured to maintain a carer-centred focus to service delivery, the Director and carers casework manager indicated that the new contract was targets-driven and difficult to deliver. Partnership working was also affected. A shift in organisational culture away from being carer-focused, to outcomes-driven would impact the potential of the CReate project to deliver services in line with an ethic of care and promote carers’ work-care reconciliation.

Partnership working, charging employers for services, and creating a social enterprise, were suggested at various stages over the project by the CReate project manager and Director of Carers’ Resource, as potential ways to ensure the financial sustainability of the CReate project. Staff did not ultimately pursue these suggestions further, however. The CReate project manager reported she wished to open either a charity shop or an ‘upcycling’ social enterprise, where they would purchase old furniture, carers would refurbish it, decorate it, and would then sell it on for a profit. The CReate project manager felt that this would also provide carers with an opportunity to develop skills relating to enterprise and retail. She stated she had faced resistance from higher management who felt it would be too risky and would require significant resources to initiate. The Director of Carers’ Resource felt that charging employers for services would be an effective way to generate income:

“I still believe that there is a very strong position for an organisation like this to be ready to pick up the opportunities, why shouldn’t they all lob in £1000, I don’t know £500? Let’s say £100, £500 or £1000 from 20 local employers and we could be providing all of their carer support and employer needs. And perhaps it just sounds too idealistic, but it seems a good way to me to improve the local community of employment”.

                                                             (Director, Carers’ Resource)

As engaging with employers in the first instance was a significant challenge for the CReate project manager, this idea was also not pursued further. As outlined, staff recruitment and retention was a significant issue and although Carers’ Resource staff made changes to the recruitment process, this remained an issue throughout the project. One of the principal ways Carers’ Resource staff negotiated the sustainability of the organisation and CReate project was by delivering publicly-funded services. Voluntary organisations often face difficulty securing funding and have increasingly been delivering publicly-funded services to ensure financial sustainability as grant funding has decreased in recent years (Benard et al 2017; Crees et al 2016). Delivering the NCS contract, however, led to mission drift and diversification of the client base. After gaining the contract to deliver the Integrated Carer Services (ICS) contract in Bradford, Carers’ Resource merged with and took over another smaller organisation which caused some initial tension within the organisation and was also not popular with some carers in the area. Government has encouraged mergers as a way to ensure sustainability, although they are often difficult to achieve in practice (Rees et al 2012). Delivering the ICS contract also resulted in mission drift as services funded were those that were more ‘practical’ in supporting carers in their caring role, rather than providing social groups and breaks for carers. The increased competition for funding in the area also had a detrimental impact on partnerships between Carers’ Resource and other organisations. Delivering publicly-funded services had implications for the role of the organisation in promoting carers’ work-care reconciliation.

*Strategic decoupling*

The methods CReate project staff used to overcome issues with demonstrating impact can be interpreted as ‘strategic decoupling’. Strategic decoupling refers to when an organisation commits to satisfying a funder’s targets but may be selective in the information they report (Arvidson and Lyon 2014; Turco 2012; Asdal 2011; Levay and Waks 2009). Organisations do not completely resist the demand to demonstrate impact, nor are they wholly compliant, but carry out what is required for funders, whilst also influencing how the impact of an organisation is measured and understood (Arvidson and Lyon 2013). In this way, organisations can maintain a good working relationship with funders whilst ensuring some control over service delivery and evaluation. As CReate project staff had not used evaluation and reporting forms, statistics regarding outcomes of carers who accessed the project were limited. CReate project staff assumed for the purposes of the evaluation that carers had achieved the required outcomes by accessing services, indicated in Chapter 5. One of the targets outlined in the initial bid for funding, for example, was ‘carers will report that they have improved knowledge about how to access information about work and learning opportunities’. It was assumed that by attending one or more one-to-one appointments with a CReate adviser that this outcome was met. Similarly, it was assumed that if training was delivered to employers that the outcome ‘organisations will have reported that they are better informed about carers’ needs’, was met.

According to CReate project staff, they knew the project had had a positive impact for many carers, and monitoring and evaluating the project for BIG Lottery was necessary to secure further funding. Voluntary organisations can exert control through evaluations by using their discretion in relation to how they measure and report impact (Arvidson and Lyon 2014). The approach of CReate project staff to evaluation aligns with the concept of strategic decoupling. CReate project staff fulfilled the evaluation requirements of the BIG Lottery and maintained a good working relationship with the grant manager, whilst continuing to deliver services they felt most appropriate for carers and demonstrating impact to secure future funding. Strategic decoupling, however, is often an active choice and a form of resistance against control exerted by funders. In this case, CReate project staff did not consciously seek to resist the demands of BIG Lottery funders, but exerted their discretion regarding how impact was measured and what was reported. Carers’ Resource and CReate project staff negotiated sustainability primarily by delivering publicly-funded services and through strategic decoupling. Strategic decoupling enabled CReate project staff to demonstrate the impact of the project on their own terms. Delivering publicly-funded services, however, has significant implications for the ability of the CReate project to implement services in accordance with an ethic of care which Chapter 7 indicated was important for promoting carers’ work-care reconciliation.

## 8.4 To what extent did CReate project staff achieve sustainability?

Although the CReate project faced challenges securing funding, Carers’ Resource had been delivering work-care reconciliation support in some form since 1999. As outlined previously, Carers’ Resource applied to the BIG Lottery fund to extend CReate project funding. The bid was successful. According to a member of Carers’ Resource development team, the evaluation formed a significant part of the bid. The terms and conditions to the new contract, however, are slightly different. Carers’ Resource received £400,000 to deliver services for four years in Bradford, as well as North Yorkshire and Craven. Initially, the project received £300,000 to deliver services for three years in Bradford only (Chapter 5). The development team member reported that funding will provide two part-time staff in Bradford and one part-time in each of North Yorkshire and Craven, as well as a manager. Consequently, Carers’ Resource have less resources available to deliver services in a wider area. One of BIG Lottery’s requirements for funding extensions is that organisations should show what they have learnt from the previous project and how they have made improvements. Funding cannot be sought to deliver the same services as previously. The Director of Carers’ Resource expressed frustration at this:

“As they come into more common usage and common acceptance, then the frustration is, you have to wait while others catch up, and as you will have picked up from us, where we have been successful with three year grants or contracts or whatever, very often when you go back to a funder, they’re often looking actually for something very different, and all you want to do is to say give me some more of the same money and that is very frustrating”.

 (Director, Carers’ Resource)

According to the CReate project development team member, the project will now focus on supporting carers in employment to combine work and care and supporting carers to pursue self-employment. The CReate project manager acknowledged that the low number of carers in employment who accessed the project was a limitation. Self-employment emerged as a popular option for many carers and was not a priority within the original bid for funding. BIG Lottery informed Carers’ Resource in June 2017 that their application for funding was successful. By this time, however, all CReate project staff had left the organisation. The two advisers moved on when the funding ended and the CReate project manager retired. New members of staff had to be recruited for all areas and the new CReate project eventually launched in January 2017, nine months after the previous BIG Lottery funding ended. As a result, CReate project staff will need to re-build relationships with carers who previously accessed the project and with partner organisations.

It will also be necessary to promote and raise awareness of the project in the two new areas, as well as in Bradford. Nevertheless, Carers’ Resource ensured the financial sustainability of the CReate project for a further four years. Further, BIG Lottery funding should enable the CReate project to continue to deliver services in line with an ethic of care and support work-care reconciliation. It will be essential, however, to recruit and retain appropriate staff. Some previous studies examine the ways voluntary organisations negotiate sustainability (Macmillan et al 2013; Milbourne 2013; Robinson and Chapman 2013). The CReate project provides an example of what Milbourne (2013) terms a ‘resistor’; an organisation which refuses to compromise its values but also secures funding to deliver services. Carers’ Resource adapted to changes in the external environment but aimed to prioritise carers’ support needs.

## 8.5 Summary

The chapter examined the specific challenges to sustainability the CReate project faced during the project and how these were negotiated in practice. It also considered the implications for the role of the CReate project in delivering services in line with an ethic of care and promoting carers’ work-care reconciliation. Evidence from the case study indicated that the principal challenges to sustainability the CReate project faced can be interpreted as: securing funding; demonstrating impact; and recruiting and retaining staff. The ways Carers’ Resource staff negotiated these challenges in practice can be understood as: delivering publicly-funded services and strategic decoupling. Recruiting and retaining staff, however, remained an issue throughout the project. Ultimately, Carers’ Resource secured the sustainability of the project for a further four years by successfully bidding for an extension to BIG Lottery funding. The challenges to sustainability that the CReate project and Carers’ Resource faced, however, threaten the ability of the project to deliver services in line with an ethic of care and promote carers’ work-care reconciliation.

# Chapter 9: Conclusion

## 9.1 Introduction

The thesis provides unique in-depth insight into the role voluntary organisations can play in promoting carers’ work-care reconciliation. A single case study research design enabled longitudinal research into the design, implementation, and impact of a work-care reconciliation project delivered by a voluntary organisation to be undertaken. The study is unique in providing evidence, over time, of how a well-established voluntary organisation implemented and operated a work-care reconciliation project, the challenges it faced, and the successes it achieved. The thesis brings together research and concepts from work-care reconciliation and voluntary sector literature, to contribute to our theoretical understanding of the role voluntary organisations can play in promoting carers’ work-care reconciliation and debates regarding how carers can be supported to combine work and care and the changing role of voluntary organisations in society. By focusing analysis on relationships, the thesis examines the specific social processes, practices, and behaviours, important for combining work and care.

Overall, it is argued in the thesis that voluntary organisations can promote carers’ work-care reconciliation by delivering person-centred support and working with employers to create carer-friendly workplaces. Policy implementation, partnership working, and social inclusion, as defined in relation to an ethic of care, are important for understanding the role voluntary organisations can play, and the norms, forms, and space of civil society are conducive to implementing services characterised by the principles of an ethic of care. Challenges to sustainability voluntary organisations providing work-care reconciliation support face, however, may limit their ability to implement services in line with an ethic of care, and so promote carers’ work-care reconciliation.

## 9.2 Research implications

The thesis makes several original contributions to knowledge regarding the role that voluntary organisations can play in promoting carers’ work-care reconciliation. The thesis makes the following empirical and theoretical contributions.

**An in-depth view into the specific role voluntary organisations can play in promoting carers’ work-care reconciliation**

The thesis provides unique longitudinal insight into the specific role voluntary organisations can play in promoting carers’ work-care reconciliation (Research Question 1). Chapter 3 demonstrated that although voluntary organisations can play a role in supporting carers to combine work and care (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011a; Vickerstaff et al 2009; Yeandle and Formby 2005), the specific role they can play, remained under-researched. Chapters 2 and 3 indicated that further longitudinal research, which focuses analysis on the relationships and social processes that promote carers’ work-care reconciliation, would be beneficial. Empirically, Chapter 6 provided unique insight into the design, implementation and impact of a voluntary sector project which provided services to promote carers’ work-care reconciliation. The longitudinal case study approach used and tracking ten carers as they progressed through the project, enabled the impact of the project to be examined, whilst taking into account carers’ and employers’ individual circumstances, as well as the context and policy context.

Chapter 6 demonstrated that the CReate project promoted carers’ work-care reconciliation by ‘delivering person-centred support’ and working with employers to ‘create carer-friendly workplaces’. Evidence from the CReate project supports previous research which indicates that delivering person-centred support is important for promoting carers’ work-care reconciliation (Kröger and Yeandle 2013; Hamblin and Hoff, 2012; Vickerstaff et al, 2009; Yeandle et al, 2007b; Arksey et al, 2005). The thesis, however, sheds light on how person-centred support for carers can be delivered in practice and with what success, factors not considered in-depth, or over time, in previous research.

Chapter 2 indicated that creating carer-friendly workplaces is important for work-care reconciliation and that the line manager plays a crucial role in supporting carers in the workplace (Hamblin and Hoff 2012; McCarthy et al 2010; Hegewisch 2009; Higgins et al 2008; Yeandle et al 2003; Glynn et al 2002; Phillips et al 2002; Yeandle et al 2002; Lewis 1997). Previous research, however, had not considered how line managers are supported to create carer-friendly workplaces, and with what success. Evidence from the CReate project, presented in the thesis, provides new insight into how a voluntary organisation attempted to engage with employers, how they delivered support for employers in practice, and the barriers to supporting employers to create carer-friendly workplaces they faced. Chapter 6 also indicated that whilst the CReate project provided carers with practical and emotional support to pursue their goals regarding work and care, factors within the state, market and family affected their work-care reconciliation. As outlined in Chapter 2, the factors which affect carers’ work-care reconciliation are well-established (see Kröger and Yeandle 2013; Fetton and Mearns 2012; Vickerstaff et al 2009; Yeandle et al 2007b; Stiell et al 2006; Arksey et al 2005), however, evidence from the CReate project provides unique insight into the role voluntary organisations can play, in conjunction with actors in the state, market and family, in promoting work-care reconciliation for carers.

**Theoretical understanding of the role voluntary organisations can play in promoting carers’ work-care reconciliation.**

The thesis contributes to our theoretical understanding of the role voluntary organisations can play in promoting carers’ work-care reconciliation. Chapter 2 argued that theories and concepts used in previous research to examine work-care reconciliation (role theory, boundary theory and commodification of care) do not adequately explain the processes which promote carers’ work-care reconciliation in practice. They are cross-sectional rather than longitudinal, do not focus on social relationships, and do not incorporate a commitment to challenging inequalities. They also do not consider civil society. Chapter 3 indicated that previous research regarding the role of voluntary organisations in promoting carers’ work-care reconciliation does not attempt to theorise the relationships important for understanding their role. Through constructivist grounded theory, and by focusing analysis on relationships, the thesis develops a theoretical understanding of the role voluntary organisations can play in supporting carers’ work-care reconciliation, and sheds new light on the relationships and social processes which are important.

Analysis of evidence from the CReate project provides unique insight into how voluntary organisations can promote carers’ work-care reconciliation in practice (Research Question 2). Chapters 3 and 7 demonstrate the importance of civil society and policy implementation, partnership working and social inclusion in relation to an ethic of care, for understanding how and why voluntary organisations can promote carers’ work-care reconciliation. Longitudinal case studies used in the thesis, shed new light on how these processes can support carers to combine work and care in practice. Evidence presented indicates that, ultimately, the moral and political principles of an ethic of care are important for understanding the role that voluntary organisations can play. Chapters 3 and 7 also demonstrate the utility of ‘civil society’ as a theoretical concept in understanding their role and the norms, forms and space of civil society are conducive to implementing services in line with an ethic of care. Evidence presented in the thesis indicates that an ethic of care framework can expand the conceptualisation of work-care reconciliation to include civil society, social relationships and a longitudinal perspective.

**The specific challenges to sustainability voluntary organisations providing work-care reconciliation support can face and how they can be negotiated in practice**

The thesis provides unique insight into the specific challenges to sustainability voluntary organisations providing work-care reconciliation support can face and how they can be negotiated in practice, over time (Research Question 3). Although previous studies note that voluntary organisations delivering work-care reconciliation support often face challenges to sustainability (Wigfield and Marangozov 2014; Yeandle and Wigfield 2011a, 2011b), these studies do not examine the specific challenges faced contemporaneously, or how these challenges can be negotiated in practice. Chapter 8 in the thesis presents evidence regarding the challenges to sustainability Carers’ Resource and CReate project staff faced, and the ways they sought to overcome them. It demonstrates that the principal challenges to sustainability CReate project staff faced were securing funding, demonstrating impact, and recruiting and retaining staff. Carers’ Resource staff negotiated these challenges primarily by delivering publicly-funded services and through strategic decoupling. The challenges faced, however, had significant implications for the ability of CReate project staff to deliver services in line with an ethic of care, and so to promote carers’ work-care reconciliation.

Although findings from a single case study are not generalisable (Yin 1994), data presented in Chapter 8 also contributes to debates regarding the (changing) role of voluntary organisations in society. Previous research examined in Chapter 3 indicates that voluntary organisations often face challenges delivering publicly-funded services, including; procurement and commissioning; service delivery; partnership working; demonstrating impact; and recruiting and retaining staff (Rees and Mullins 2016; Milbourne 2013; Rees et al 2013; Nickson et al 2012; Cunningham and James 2011; Macmillan 2010; Ellis and Gregory 2008). Due to the changing environment in which voluntary organisations operate, and a shift towards delivering publicly-funded services, organisations can experience: mission drift; hybridisation; polarisation between organisations; institutional isomorphism; and compromised independence (Heins and Bennett 2016; Baring Foundation 2014; Billis 2010; Cairns et al 2010; Macmillan 2010; Shared Intelligence 2009; Rees 2008; Cairns et al 2006). Similarly, evidence from the CReate project demonstrated that delivering NCS (National Careers Service) services resulted in mission drift as the client base diversified. CReate project staff also found the contractual obligations of service delivery demanding; delivering the Integrated Carers Service contract resulted in tensions with other local voluntary organisations and Carers’ Resource staff found the service delivery targets difficult to deliver. The thesis contributes to the (growing) evidence base regarding the experiences of voluntary organisations delivering publicly-funded services.

Chapter 8 also sheds new light on some of the issues voluntary organisations can face recruiting and retaining staff in practice. Some previous research suggests that organisations face difficulty regarding recruitment and retention due to short-term contracts and insecurity within the voluntary sector (AGCC 2014; Cunningham and James 2007). Evidence from the CReate project indicates that one member of staff certainly left the organisation due to job insecurity and Carers’ Resource found it difficult to recruit people with the appropriate skill set. CReate project staff, however, also faced issues regarding ‘job embeddedness’, an issue for organisations in all sectors. Voluntary organisations are also increasingly expected to demonstrate impact, often as a funding requirement (Teasdale et al 2012). The BIG Lottery Fund required CReate project staff to produce monitoring reports during the project and an evaluation at the end. Reflecting findings from some previous research (Arvidson and Kara 2014; Ogaìn et al 2012; Ellis and Gregory 2008), CReate project staff did not have the resources in terms of personnel to maintain service delivery and undertake the evaluation and consequently, Carers’ Resource appointed a volunteer to collate evidence. Although CReate project staff often did not use monitoring and evaluation tools developed at the beginning of the project, they used a process of ‘strategic decoupling’ which enabled them to satisfy funding monitoring requirements whilst maintaining control over how they demonstrated impact and the information provided. The thesis provides further insight into the challenges voluntary organisations can face demonstrating impact and how organisations can seek to overcome them.

The thesis makes several original contributions to knowledge. Empirically, it provides an in-depth and longitudinal view of the role voluntary organisations can play in promoting carers’ work-care reconciliation, including how person-centred support can be delivered in practice and how employers can be supported to create carer-friendly workplaces. The thesis develops a theoretical understanding of the social processes important for supporting carers’ work-care reconciliation and for understanding the role that voluntary organisations can play. It demonstrates how the moral and political principles of an ethic of care can expand the conceptualisation of work-care reconciliation to include civil society, a longitudinal perspective and social relationships. The thesis also sheds light on the specific challenges to sustainability voluntary organisations delivering work-care reconciliation support can face and how these can be negotiated in practice, over time.

## 9.3 Implications for policy and practice

The thesis findings have several implications for policy and practice.

**For policy:**

**Recognising the role voluntary organisations can play in promoting carers’ work-care reconciliation**

The need to support carers to combine work and care or return to work is now recognised in policy. The National Carers’ Strategies emphasise the importance of supporting carers to pursue employment and ‘have a life of their own’ outside of caring (HM Government 2010, 2008) and some policy provisions are now available for carers (see Chapter 1, Table 1.1). Whilst the National Carers’ Strategies (2010, 2008) refer to the important role voluntary organisations can play in supporting carers in their caring role, voluntary organisations are not adequately conceptualised in policy as playing a role in promoting carers’ work-care reconciliation. Chapter 2 indicated that carers highly value the support available through voluntary organisations and often prefer to access this more informal support, than more formal statutory provisions (Carers UK and Age UK 2016; van Wanrooy et al 2013; Kröger and Yeandle 2013; Fetton and Mearns 2012; Tipping et al 2012; Pritchard 2011; Vickerstaff et al 2009; Yeandle et al 2007b; Stiell et al 2006; Arksey et al 2005). Evidence from the case study presented in Chapter 6 demonstrates the specific role voluntary organisations can play in work-care reconciliation and Chapters 3 and 7 provide a theoretical understanding of how voluntary organisations can promote carers’ work-care reconciliation in practice. Policy-makers should recognise the role that voluntary organisations can play in supporting carers to combine work and care or return to work.

**Training for line managers**

Previous research and evidence from the case study indicates that training for line managers on supporting carers in the workplace is essential for creating carer-friendly workplaces (Yeandle et al 2003; Yeandle et al 2002). Carers and line managers are often not aware of workplace support available for carers (Carers UK and Age UK 2016; Fetton and Mearns 2012; Vickerstaff et al 2009; Stiell et al 2006). Evidence from the CReate project presented in Chapters 6 and 7 indicated that training for line managers can result in changes being made in the workplace to support carers’ work-care reconciliation. Renford, for example, following CReate project training, made changes to their workplace policies to better support carers, introduced a carers’ champion and regularly circulated information regarding local carer support services available to their employees. Managers who attended the training also reported increased awareness in the challenges that carers face combining work and care and an increased uptake of carers passports. Training for line managers on supporting carers in the workplace should be mandatory. Employers for Carers have developed a training package for line managers[[70]](#footnote-70) which could be delivered nationally. Local carers centres could provide input regarding the services available in the local area. Training could be delivered by local carer centre staff, although it would be essential they had adequate funding and resources to do so.

**Carer’s leave**

One of the carers tracked through the project mentioned that carer’s leave would be particularly beneficial for her to combine work and care, as she had to take time off to go to hospital appointments with her son, but her line manager was not understanding. Currently, carers in the UK are only entitled to time off in an emergency, and although there is no defined time limit, it is often short term and unpaid (Carers UK 2013). Carers UK (2013) make the case for introducing statutory carer's leave and argue it would support carers to combine work and care and so also financially benefit businesses and the economy. Several other countries internationally have introduced a form of carer’s leave and Colombo et al (2011) argue that as parental leave has had a positive effect on parents’ (particularly mothers’) work-childcare reconciliation, carer’s leave could support carers to remain in employment or return to work. Policy-makers should further investigate the potential for introducing carer’s leave in the UK, although as Colombo et al (2011) state, it would need to be flexible and able to take into account the often-changing nature of caring responsibilities.

**A partnership approach to supporting work-care reconciliation**

Evidence from previous research presented in Chapter 2 and findings from the case study in the thesis indicate that actors within all spheres of society – the family, the state, the market and civil society, play a role in promoting carers’ work-care reconciliation. Chapter 6 indicated that although the CReate project developed the confidence and motivation of carers tracked through the project to pursue their goals regarding work and care, the policy and funding context in which it operated, affected the project’s impact. Chapters 3 and 7 also demonstrated the importance of partnership working in understanding the role that voluntary organisations can play in promoting carers’ work-care reconciliation. Consequently, it is important for all spheres of society to work together to support carers to combine work and care. Policy-makers need to recognise the role that voluntary organisations can play and emphasise the importance of all sectors in society working together. Local consortiums could be developed with representatives from health and social care, voluntary organisations, local employers and carers, to develop support, share information and develop a coherent approach to supporting carers that would benefit all parties.

**Funding for voluntary organisations to provide work-care reconciliation support**

Securing funding was a key challenge faced by Carers’ Resource staff and was also identified as an issue in previous research regarding the role of voluntary organisations in supporting carers (Wigfield and Marangozov 2014; Yeandle et al 2011a, 2011b). As a way to ensure sustainability, Carers’ Resource, and many other voluntary organisations, have delivered publicly-funded services. Organisations delivering publicly-funded services, however, can face challenges delivering contracts in practice. Previous research suggests that delivering publicly-funded services contributes to the ‘marketisation’ of voluntary organisations and ‘blurring of boundaries’ between sectors, which affects voluntary organisations’ ability to support their core client groups and their social sustainability (Civil Exchange 2016; Baring Foundation 2013, 2014; Aiken and Bode 2009; Carmel and Harlock 2008; Charity Commission 2007; Wolch 1990). Evidence from Carers’ Resource indicated that challenges to sustainability could affect their ability to deliver services in line with an ethic of care and promote carers’ work-care reconciliation.

Voluntary organisations often form to provide specific services to a specific client group, who may be marginalised or require support not available through the state or market (Hansmann 1987, 1980; Weisbrod 1977). Evidence from the CReate project presented in the thesis indicates that female carers and Pakistani carers, who are also most likely to be carers and often face difficulty combining work and care, were highly represented in the project. Government and local government should consider how voluntary organisations, including voluntary organisations providing work-care reconciliation support, can be funded within this changing environment, without compromising their values. Funding should ideally be for a minimum of five years to give organisations time to establish projects, develop awareness, generate referrals, and develop a sustainable service. BIG Lottery Fund, within their ‘Reaching Communities’ funding stream now seek to fund projects and programmes which will make ‘sustainable changes’ for people and communities and view grant funding for at least four years as the most appropriate way to achieve this (BIG Lottery 2017).

**Supporting voluntary organisations to demonstrate impact**

Voluntary sector policy needs to recognise that voluntary organisations often face difficulty demonstrating impact and sometimes do not have the resources or expertise to do so. So that voluntary organisation staff can focus on service delivery and not be overwhelmed with monitoring and evaluation systems, it is important they are supported to demonstrate impact and provide the information required by funders. An online resource for voluntary organisations could be developed with information and advice regarding different evaluation methods. Funders also need to be clear regarding reporting requirements and work with voluntary organisations to develop appropriate monitoring and evaluation systems. Evidence from the CReate project presented in the thesis indicated that they faced difficulty demonstrating impact as high staff turnover meant CReate project staff had insufficient time and resources to monitor the project. A comprehensive monitoring system for all staff to use was also not developed and implemented at the beginning of the project. Voluntary sector funders should ensure organisations have sufficient monitoring systems in place and support organisations to develop their monitoring and evaluation systems in line with their requirements at the beginning prior to the start of a funding contract.

**For practice:**

For Carers’ Resource/ CReate project:

**Delivering services in accordance with the principles of an ethic of care**

Evidence from the case study presented in Chapter 7 demonstrates that delivering services in line with an ethic of care was essential for the CReate project to support work-care reconciliation. The moral and political principles of an ethic of care could provide a framework for service delivery.

**Training for line managers**

CReate project staff could investigate the potential for carers to play an active role in designing and delivering training for line managers, and ensure training incorporates carers’ voice. Carers’ stories appeared to resonate most with managers at Renford, used as a case study example.

**Engaging with carers in employment**

CReate project staff engaged with a low number of carers in employment, which was a limitation to the project. Attending events within workplaces, such as the employee event at Renford (outlined in Chapter 6, Box 3), appeared to be an effective way of engaging with carers in employment and the potential to attend further workplace events should be investigated.

**Ensuring effective monitoring and evaluation systems are in place**

Evidence from the case study indicated the importance of having effective monitoring and evaluation systems in place for ease of collating data at the end of the project. Prior to delivering services within the next round of BIG Lottery funding, Carers’ Resource should ensure monitoring and evaluation systems are in place and that all staff are aware of and use these systems in the same way. This would ensure that CReate project staff are able to focus on service delivery and when monitoring and evaluation data is required, data is readily available.

## 9.4 Limitations of study

As a single case study, generalisations cannot be made from this study. Although undertaking an in-depth single case study provides unique insight into the role voluntary organisations can play in promoting carers’ work-care reconciliation and the social processes important for understanding their role, the findings are not applicable to all voluntary organisations, or carers, and are context-specific. Further quantitative data would have been beneficial to gain a broader overview of the impact of the project for carers and would have enabled further in-depth, multivariate analysis to be undertaken. Nevertheless, the theoretical concepts developed can be tested and applied in other contexts and further research.

## 9.5 Directions for future research

Further research regarding the role of voluntary organisations in supporting work-care reconciliation would be beneficial. As a single case study was undertaken, with further case studies, the thesis findings could be tested in different contexts. Future research could also test whether delivering services in line with an ethic of care is an effective way of delivering services and supporting carers to combine work and care. As evidence indicates a partnership approach to supporting work-care reconciliation is necessary, research into how consortiums could be established and their potential role in supporting carers would be beneficial. Evidence from the case study suggests a carers charter mark is potentially an effective way to engage with employers and encourage them to implement carer-friendly working practices. Research could be undertaken to investigate this further, and whether gaining a carers charter mark results in carers feeling supported in the workplace. Similarly, research could examine the role of carer’s champions and carers passports in supporting carers in the workplace.

## 9.6 Concluding Thoughts

The thesis provides unique insight into the role voluntary organisations can play in promoting carers’ work-care reconciliation. Undertaking a longitudinal case study of a work-care reconciliation project delivered by a voluntary organisation provides an in-depth view of the design, implementation and impact for carers and employers, whilst taking the policy and funding context into account. Analysing relationships (in line with constructivist grounded theory and an ethic of care perspective), enabled a theoretical understanding of the social processes important for understanding carers’ work-care reconciliation and the role voluntary organisations can play, to be developed. Overall, it is argued in the thesis that voluntary organisations can promote carers’ work-care reconciliation by delivering person-centred support and working with employers to create carer-friendly workplaces. The moral and political principles of an ethic of care are important for understanding how voluntary organisations can support carers and the concept ‘civil society’, in terms of forms, norms and space, helps explain why voluntary organisations can promote carers’ work-care reconciliation in practice. The thesis indicates, however, that the changing environment within which voluntary organisations operate, and the challenges to sustainability voluntary organisations providing work-care reconciliation support can face, affects their ability to implement services in line with an ethic of care, and to promote carers’ work-care reconciliation.

# Appendices

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## A1. Participant Information Sheet: Example

PhD Research Study

**Title of research: The role of voluntary organisations in providing employment support to carers: a case study of the CReate project**

**INFORMATION SHEET FOR PARTICIPANTS**

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish and please ask if there is anything that is not clear or if you would like further information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

**What is the purpose of the study?**

This project aims to contribute to the understanding of the role of voluntary organisations in providing employment support to carers.  It seeks to explore to what extent the CReate project delivers services that are beneficial for both carers and employers. You are being invited to take part in this study as you have accessed one or more of the CReate project’s services.

**What will participation involve?**

If you agree to take part, participation will involve an initial face-to-face interview, which will take approximately 1 hour. With your permission, I would then observe the activities that you undertake with the CReate project. A follow-up interview also lasting approximately an hour would then be undertaken when your involvement with the CReate project comes to an end.

**What are the possible risks involved?**

There are no known risks or disadvantages of taking part, as your confidentiality will be protected.

**What are the potential benefits of taking part?**

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will be an opportunity for you to express your views and experiences of the CReate project.

**Will my taking part in this project be kept confidential?**

The interviews will be tape recorded and later transcribed into text form. Recordings of interviews will then be deleted. As part of the presentation of your results, your own words may be used in text form. This will be anonymised so that you cannot be identified from what you said. All of the research data will be stored as hard copy at University of Leeds for 1 year.

Please note that:

* You can decide to stop the interview at any point
* You need not answer questions that you do not wish to
* Your name will be removed from the information and anonymised. It should not be possible to identify anyone from my reports on this study.

It is up to you to decide whether to take part or not. If you decide to take part you are still free to withdraw from participating at any time without giving a reason. If you withdraw from the study all data will be withdrawn and destroyed.

If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

If this study has harmed you in any way you can contact Leeds University using the details below for further advice and information:

Professor Sue Yeandle

CIRCLE (Centre for International Research on Care Labour & Equalities),

School of Sociology and Social Policy,
University of Leeds,
LEEDS,
LS2 9JT

s.m.yeandle@leeds.ac.uk

**0113 343 5003**

**Contact for further information:**

Jenny Read

School of Sociology and Social Policy,
University of Leeds,
LEEDS,
LS2 9JT

ssjr@leeds.ac.uk

Tel 01274 531 377 (Carers’ Resource)

Thank you for reading this information sheet.

## A2. Participant Consent Form: Example

**Participant Consent Form**

**Title of research project**: The role of voluntary organisations in providing employment support to carers: a case study of the CReate project

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of researcher:**  Jenny Read Contact Details: ssjr@leeds.ac.uk     Tel.  01274 449660*Initial the box if you agree with the statement to the left*

|  |  |
| --- | --- |
| 1. I confirm that I have read and understood the information sheet provided explaining my research project and I have had the opportunity to ask any questions or clarify any concerns about the project.
 |  |
| 1. I understand that my participation is voluntary and that I am free to withdraw at any time without having to give a reason. Furthermore, I am free to decline to answer any questions should I not wish to.
 |  |
| 1. I understand that my responses will be kept strictly confidential and that I will not be identified or identifiable in any reports that result from the research.
 |  |
| 1. I agree that the data collected from me can be used in future research.
 |  |
| 1. I agree to take part in the above research project and will inform the principal investigator should my contact details change.
 |  |

Name of participant              Date                     SignatureResearcher                               Date                    Signature  |

## A3. Carers interview guide

**Title: The role of voluntary organisations in providing employment support for carers: a case study of the CReate project**

Script for beginning: Welcome and thank you for your participation today. My name is Jenny Read and I am a PhD student at Leeds University researching the role of voluntary organisations in providing employment support for carers. My study broadly aims to understand and explain how and why voluntary organisations have been delivering employment support services for carers and specifically, to what extent the CReate project has provided a service from which both carers and employers benefit. My study is not aiming to evaluate the CReate project, but I am trying to gain an understanding of your experiences of the CReate project and learn about the impact that the project may have had for you in your decisions surrounding work and care.

People of working age are the largest group in society providing unpaid care to sick, elderly or disabled people and government has increasingly emphasised the role of voluntary organisations in supporting carers, this is therefore an important topic to study.

This interview will take about an hour to an hour and a half and will include approximately 8 questions regarding your experiences of combining work and care or returning to work and the services of the CReate project. I believe your input will be valuable to this research and in understanding the role of voluntary organisations delivering employment support services for carers.

I would like your permission to record this interview, so I may accurately document the information that you share. If at any time you wish to discontinue recording or stop the interview itself, please feel free to let me know. All of your responses will be confidential. Your responses will remain confidential and will be used to develop an understanding of your experiences of the CReate project and the impact that it may have had on your decisions surrounding work and care.

At this time I would like to remind you of your written consent to participate in this study. I am the responsible investigator, you and I have both signed and dated each copy, certifying that we agree to continue this interview. You will receive one copy and I will keep the other locked in my drawers at university and kept separately from your responses today.

Your participation in this interview is completely voluntary. If at any time you need to stop or take a break or return to something, please let me know. You may also withdraw from participating in this study at any time, and with no consequences. Do you have any questions or concerns before we begin? Then, with your permission we will begin the interview.

Date:

Time:

Location:

Interviewer:

Participant:

Release form signed?

**Themes:**

1. **Participant Background** (discuss in relation to timeline)
* Caring responsibilities – whether still a carer/ caring responsibilities have come to an end, how long have been a carer for, how many hours a week roughly care for, who care for.
* Circumstances regarding work and care – whether have left work to care or combining work and care?
* Previous employment/ training undertaken
1. **Experiences of combining work and care, returning to work or accessing education or training** (discuss in relation to timeline)

**Tell me about your experiences of combining work and care/ returning to work and getting into work or training**

* Whether had difficulty with employer, whether have been able to successfully combine work and care
* If left the labour market to care, reasons for this
* When decided to return to work or decided wanted to access education or training, whether felt support was available, whether knew where to find information, whether felt supported in this.
1. **Accessing the CReate project**

**Why was it that you decided to engage with the CReate project?**

* How did you hear about the CReate project?
* Were you referred from another organisation?
* Why did you decide to contact Carers’ Resource/ CReate project?

1. **Aims at beginning of project**

 **What were you hoping to achieve from engaging with the CReate project?**

1. **Experiences of the CReate project**

 **Walk me through your experiences of the CReate project**

* What activities and services have you accessed and what have your experiences of these been?
* How did you feel about the way in which the activities were delivered?
* Did members of staff have sufficient expertise?
* What aspects of the project have you found the most helpful/ the least helpful?
* Were there any issues regarding accessibility or flexibility of services?
1. **CReate project in comparison to other services that may have been accessed**

**Have you accessed any other employment and training support services?**

* And if so, how would you say the CReate project compares to other employment and training support services that you have accessed?
* Have you accessed employment support from public, private or other voluntary organisations?
* Was there a difference between different sector providers?
1. **Impact/ outcomes of the CReate project**

**Would you say that the CReate project has had an impact for you? If so, what would you say the impact of accessing the CReate project has been for you?**

* Has accessing the CReate project affected your decisions around work and care and why/ why not?
* What has happened since accessing the project/ as a result of accessing the    project?
* Has accessing the CReate project enabled you to have a life outside of caring? Feel more informed about rights regarding work and care?
* Did the project meet your expectations? Is there anything that you feel could be done differently or any other services that would be beneficial for the CReate project to offer?
* What is your current situation in terms of work and care and future plans?
* Have policy factors such as Carer’s Allowance, inflexible jobs, inflexible employers, inadequate care services presented an issue in being able to combine work and care or return to work, despite accessing the CReate project?
1. **Is there anything else that you feel is important in understanding your experiences of the CReate project/ of your experience combining work and care or returning to/ entering employment, education or training?**

**Closure:**

- Thank you to participant

- How I am going to proceed from here - Methods of disseminating results

* Reassure confidentiality
* Ask permission to follow up
* Provide my contact details

## A4. Carers’ Resource key personnel interview guide

Interview protocol for key personnel:

**Title: The role of voluntary organisations in providing employment support for carers: a case study of the CReate project**

Script for beginning: Welcome and thank you for your participation today. My study is aiming to explore to what extent the Create project has provided a service from which both carers and employers benefit. I am not aiming to evaluate the Create project, but I am trying to gain an understanding of how the project has been designed and implemented, challenges of sustainability that have arisen and how and why relationships with other organisations and agencies change during the project.

This interview will take about an hour to an hour and a half and will include approximately 6 questions regarding the design and implementation of the CReate project, challenges of sustainability and relationships with other organisations.

I would like your permission to record this interview, so I may accurately document the information that you share. If at any time you wish to discontinue recording or stop the interview itself, please feel free to let me know. All of your responses will be confidential. Your responses will remain confidential and will be used to better develop an understanding of your experiences of the CReate project and the impact that it may have had on your decisions surrounding work and care.

If could now sign the participant consent form. You will receive one copy and I will keep the other locked in my drawers at university and kept separately from your responses today.

Your participation in this interview is completely voluntary. If at any time you need to stop or take a break or return to something, please let me know. You may also withdraw from participating in this study at any time, and with no consequences. Do you have any questions or concerns before we begin? Then, with your permission we will begin the interview.

Date:

Time:

Location:

Interviewer:

Participant:

Release form signed?

Approximate length of interview: 1 hour

**Key Themes – which will vary slightly depending on the participant**

**1. Participant Background**

* Previous work experience
* Why decided to apply for a job/ to volunteer at Carers’ Resource

**2, Development of the project**

**Tell me about the development of the CReate project**

* Why was the project developed?
* On what basis was it decided that the service was needed?

**2. Aims of the project:**

**What are the main aims of the CReate project?**

* Why are these the aims and how were they decided upon?
* What has the influence of the funding been on the aims? – were the aims developed to correspond to funding requirements or to secure funding?
* What input did clients/ carers have?

**3. Design of the project**

**Having secured funding from the BIG Lottery Fund, how did you decide which activities and services to deliver for carers and employers to achieve these aims?**

* What was the basis for the design of the project?
* How was it decided what activities to deliver and why - previous experience and previous Changing Lives project? Evidence from research? To complement/ challenge public policy and statutory services?
* How has the funding received from the BIG lottery fund impacted upon the design of the project?

**4.Implementation of the project**

**What techniques or behaviours do you use to generate referrals? and deliver the project’s activities?**

* Are there any specific techniques that you use to deliver the activities?
* How are referrals generated and what techniques/ behaviours are used to generate referrals?
* What training did you receive to deliver the services?
* What Carers’ Resource look for in their paid members of staff and volunteers  - what professional background, qualifications or qualities?
1. **Key challenges in implementing project:**

**What have been the main challenges in delivering the project?** (and why?)

* Generating referrals? Engaging with employers? Working with other organisations? Staffing issues?
* Have the funding requirements restricted or limited the service that is delivered?  - for example, has it meant more time has to be spent on recording evidence and evaluating the service?
* Has the public policy context, surrounding the role of voluntary organisations and cuts to public sector funding affected the service?
1. **Relationships and partnerships with other organisations**

**What have your experiences of working with other organisations been?**

-Which relationships have been successful and which ones haven’t and why?

- Relationship with statutory agencies such as Jobcentre Plus, other voluntary organisations and businesses - have there been/ are there any differences between relationships with other voluntary organisations and public and private sector organisations?

- Have many referrals been generated through relationships with other organisations?

1. **Key challenges in delivering the project sustainably and future of the project**

**What would you say are the main challenges in continuing to deliver employment support services for carers when the BIG lottery funding runs out?**

- What measures are being taken to ensure sustainability?

- What do you see for the future of the service?

- To what extent sustainability is possible within the current public policy context?

- Increasing culture of contracting?  - whether same quality service could be achieved delivering services under contract? Mission drift?

**8. Is there anything else that you feel is important in understanding the development, delivery or future of the CReate project?**

## A5. Employers interview guide

Interview protocol for employers

**Title: The role of voluntary organisations in providing employment support for carers: a case study of the CReate project**

Script for beginning: Welcome and thank you for your participation today. My study is aiming to explore to what extent the Create project has provided a service from which both carers and employers benefit. I am not aiming to evaluate the Create project, but I am trying to gain an understanding of how the project has been designed and implemented, challenges of sustainability that have arisen and your experiences of CReate project services.

This interview will take about an hour to an hour and a half and will include approximately 6 questions regarding the design and implementation of the CReate project, challenges of sustainability and relationships with other organisations.

I would like your permission to record this interview, so I may accurately document the information that you share. If at any time you wish to discontinue recording or stop the interview itself, please feel free to let me know. All of your responses will be confidential. Your responses will remain confidential and will be used to better develop an understanding of your experiences of the CReate project and the impact that it may have had on your decisions surrounding work and care.

If could now sign the participant consent form. You will receive one copy and I will keep the other locked in my drawers at university and kept separately from your responses today.

Your participation in this interview is completely voluntary. If at any time you need to stop or take a break or return to something, please let me know. You may also withdraw from participating in this study at any time, and with no consequences. Do you have any questions or concerns before we begin? Then, with your permission we will begin the interview.

Date:

Time:

Location:

Interviewer:

Participant:

Release form signed?

**Themes:**

**1. Reasons for engaging with the CReate project**

* How did you hear about Carers’ Resource/ CReate project?
* Why did you decide to engage with the project?
* Did you attend a Carers’ Resource event?

**2.Aims of working with the project**

* What did you hope to gain from working with the project?
* Is work-care reconciliation an issue in the workplace that has been brought to your attention?

**3.Experiences of CReate project services**

* What services have you accessed?
* How would you describe your experience of the project?
* Did you feel they were beneficial? Why/ why not?

**4.Impact of working with CReate project**

* Would you say there has been an impact for you from working with the CReate project?

**5. Any support services that would have been useful that weren’t offered.**

**6. Anything else would like to add regarding working with the CReate project or supporting carers in the workplace?**

## A6. Partner organisations interview guide

Interview protocol for partner organisations

**Title: The role of voluntary organisations in providing employment support for carers: a case study of the CReate project**

Script for beginning: Welcome and thank you for your participation today. My study is aiming to explore to what extent the Create project has provided a service from which both carers and employers benefit. I am not aiming to evaluate the Create project, but I am trying to gain an understanding of how the project has been designed and implemented, challenges of sustainability that have arisen and how and why relationships with other organisations and agencies change during the project.

This interview will take about an hour to an hour and a half and will include approximately 6 questions regarding the design and implementation of the CReate project, challenges of sustainability and relationships with other organisations.

I would like your permission to record this interview, so I may accurately document the information that you share. If at any time you wish to discontinue recording or stop the interview itself, please feel free to let me know. All of your responses will be confidential. Your responses will remain confidential and will be used to better develop an understanding of your experiences of the CReate project and the impact that it may have had on your decisions surrounding work and care.

If could now sign the participant consent form. You will receive one copy and I will keep the other locked in my drawers at university and kept separately from your responses today.

Your participation in this interview is completely voluntary. If at any time you need to stop or take a break or return to something, please let me know. You may also withdraw from participating in this study at any time, and with no consequences. Do you have any questions or concerns before we begin? Then, with your permission we will begin the interview.

Date:

Time:

Location:

Interviewer:

Participant:

Release form signed?

**Development of relationship**

* **How did the relationship between you and the project come about?**
* When relationship developed – history of relationship
* Whether knew each other before the start of the CR project
* How relationship was developed – who approached who
* Have you worked together previously?
* **Planning/ development of the CReate project** – were you part of the consultation process?
* Did you feel that your ideas have been listened to?
* Is there anything that you feel hasn’t been implemented that could be useful?

**Aims of relationship**

* **What would you say are the main aims of this relationship?**
* What is the purpose of this relationship?
* Why did you enter into this relationship?
* Was there a discussion around the aims of the relationship – were the aims and obligations outlined from the beginning?
* How were the goals of the relationship decided upon?
* Aims to share knowledge? To be a referral pathway?

**Nature of the relationship – relationship in practice**

* **How would you describe the nature of the relationship?**
* The relationship in practice – how it works in practice - How work in partnership – how do you work together to deliver services to carers
* How do you work together? – on what tasks do you work together?
* Would you say that it’s reciprocal?

**View of the CReate project**

* **How do you view the CReate project?**
* What are your perceptions of the CReate project?
* Do you feel that it is providing a needed and valuable service?
* Is there anything else that you feel that it could be doing?

**Barriers to partnership working**

* **Have there been any barriers to working together?**
* Whether need more regular meetings? Clearer outlines of what the relationship entails?
* Whether the co-productive approach is a help or hindrance to relationships with other organisations – whether it has an impact on other organisations
* Any changes to the relationship over the course of the project

**Outcomes of working in partnership**

* **What would you say have been the main outcomes of this relationship?**
* For you and for carers?
* At an organisational level and at the individual or carer level
* Has a result been that your organisation is now also more aware of the difficulties that carers face in combining work and care or returning to work?
* How useful has this relationship been to you?

Future of relationship

* **What would you say the future of the relationship is?**
* Do you see this relationship continuing? – why/ why not?
* How sustainable is this relationship?

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1. This is the definition used by staff in Carers’ Resource and the CReate project, the case study example used in the thesis. ‘Carer’ in the thesis does not refer to those who provide paid care, volunteers who provide care, or those providing childcare for children without a long-term illness or disability. [↑](#footnote-ref-1)
2. See Chapter 2, 2.1 for further discussion on the concept ‘work-care reconciliation’. [↑](#footnote-ref-2)
3. Caring at a distance is defined as those caring for someone who ‘may be living in another part of the town, region, country or the world’ (EfC 2011, p1). [↑](#footnote-ref-3)
4. Section 2.4 examines evidence regarding the statutory right to request flexible working. [↑](#footnote-ref-4)
5. Employers for Carers provides support to businesses to support carers in the workplace and encourages workplaces to support carers (EFC 2013). [↑](#footnote-ref-5)
6. Carer’s Allowance is the statutory benefit available for some carers (Carers UK 2015) and is explored further in Section 2.5. [↑](#footnote-ref-6)
7. Section 2.4 examines the strategies carers use to combine work and care. [↑](#footnote-ref-7)
8. Strict eligibility criteria are attached, however, and employees must have been working for an employer for at least 26 weeks, employees can only make one request in any twelve-month period and employers can reject a request for ‘sound business reasons’ (HMSO 2014). [↑](#footnote-ref-8)
9. The 2011 WERS provides information on the current state of employment relations inside British workplaces and has been undertaken intermittently since 1980 so can show changes over time (van Wanrooy et al 2013). [↑](#footnote-ref-9)
10. A Work Focused Interview is a meeting between a carer and a Jobcentre adviser to discuss re turning to work and any training or educational opportunities to assist with this (Carers UK 2014). [↑](#footnote-ref-10)
11. Section 2.5 examines the availability and use of Direct Payments in practice. [↑](#footnote-ref-11)
12. Carers centres are independent charities which offer advice, information, practical and emotional support to carers (Carers Trust 2015). [↑](#footnote-ref-12)
13. Section 2.5 discusses ‘cash-for-care’ schemes. [↑](#footnote-ref-13)
14. For in-depth discussion of personalisation see Beresford (2014), Needham (2011) and Leadbeater (2004). [↑](#footnote-ref-14)
15. New Public Management is a term coined from the late 1980s ‘to denote a new (or renewed)

stress on the importance of management and ‘production engineering’ in public service delivery,

often linked to doctrines of economic rationalism’ (Hood and Peters 2004). [↑](#footnote-ref-15)
16. Care in the Community refers to the shift away from institutionalised care to caring for people in their homes, adopted in policy in the 1980s in particular (Griffiths 1988). [↑](#footnote-ref-16)
17. The Independent Living Movement, which originated in the US in the 1960s, emphasizes that disabled people are the best experts on their own needs (National Council on Independent Living (NCIL) 2018).   [↑](#footnote-ref-17)
18. With Individual Budgets, the recipient is advised of the amount they are entitled to spend on services however, professionals plan and organised care and support (Duffy 2010). [↑](#footnote-ref-18)
19. Voluntary sector policy is a devolved issue in the UK (Alcock 2010) and an English case study is used for the empirical research in the thesis (see Chapter 5). [↑](#footnote-ref-19)
20. In 1978 the Wolfenden Committee outlined the role they envisaged for voluntary organisations in the UK, which, according to Brandsen et al (2006), marked a turning point in policy as focus shifted away from statutory bodies in a way which remained applicable for the following 25 years. [↑](#footnote-ref-20)
21. The Compact is an agreement between voluntary organisations and the government and outlines how they can work together for mutual benefit (Cabinet Office 2010c; Home Office1998). [↑](#footnote-ref-21)
22. The assertion that voluntary organisations develop social norms is based on little empirical evidence (Edwards and Foley 1998). [↑](#footnote-ref-22)
23. See Cairney (2012) for overview and discussion of the policy cycle. [↑](#footnote-ref-23)
24. CwC was a Department of Health (DH) funded programme which aimed to provide training and support to carers to increase choice and control in various aspects of their lives, including access to social care, combining work and care, and health (Yeandle et al 2011b). [↑](#footnote-ref-24)
25. The Demonstrator Sites programme (also funded by the DH) aimed to provide breaks for carers, carry out health and well-being checks for carers and instigate improved NHS support for carers (Yeandle et al 2011a). [↑](#footnote-ref-25)
26. According to Nyssens (2006), WISEs (Work Integration Social Enterprises) have been supporting disadvantaged people in the UK and across Europe into work since the mid-1990s (Nyssens 2006). WISEs in the UK include voluntary organisations with employment initiatives, work co-operatives, community businesses, social firms, quasi-state social enterprises and intermediate labour market organisations (Spear 2002). [↑](#footnote-ref-26)
27. There were, however, several limitations to the quantitative data available, discussed in Section 4.5. [↑](#footnote-ref-27)
28. Chapter 5 outlines the context, aims and operational arrangements of the CReate project. [↑](#footnote-ref-28)
29. Section 4.8 discusses researcher bias further. [↑](#footnote-ref-29)
30. Interview protocols used can be found in Appendices A.3-A.6 [↑](#footnote-ref-30)
31. See Appendix A.3 for full interview protocol for retrospective interviews with carers. [↑](#footnote-ref-31)
32. Interview protocols are available in Appendices A3-A6. [↑](#footnote-ref-32)
33. See Appendix A.5 for interview protocol. [↑](#footnote-ref-33)
34. Except for one phone interview with the funding grant manager when the recording equipment did not record and one line manager who objected. [↑](#footnote-ref-34)
35. As my PhD research commenced at Leeds University and ethical approval was granted through Leeds University. [↑](#footnote-ref-35)
36. See Chapter 4, Table 4.1 for an overview of the characteristics of carers tracked through the project [↑](#footnote-ref-36)
37. See Chapter 2, Section 2.3 for full discussion of person-centred approach. [↑](#footnote-ref-37)
38. Data is drawn from an initial interview, a follow-up interview, observation of three one-to-one support sessions between Pat and a CReate adviser, informal conversations held during and after these, and follow-up contact via email over nine months. [↑](#footnote-ref-38)
39. Data is drawn from observation of the Beginner’s IT Group, which ran weekly for six weeks, informal conversations with carer participants, and an interview with the volunteer who ran the groups. This group was chosen as a case study as all six sessions were observed and a high number of carers (53) accessed IT groups in comparison with other workshops (see Chapter 5, Figure 5.1). [↑](#footnote-ref-39)
40. Chapter 7 explores trust and reciprocity in further detail. [↑](#footnote-ref-40)
41. See Chapter 3 for discussion of these programmes. [↑](#footnote-ref-41)
42. Some of the specific methods CReate project staff used to engage with different groups of carers are examined in Chapter 7 Section 7.4 [↑](#footnote-ref-42)
43. This is in contrast to some previous programmes for carers (CwC and some Demonstrator Sites programmes) which faced difficulty reaching their target numbers of carers. Indeed, the Department of Health ended the CwC programme prematurely, partially due to low uptake of services (Yeandle and Wigfield 2011b). [↑](#footnote-ref-43)
44. Although 332 individual carers accessed CReate project services, data regarding the impact of CReate project support was only recorded for those who accessed support services, not training and workshops. 222 carers accessed one-to-one support services, although 67 of these also accessed training and workshops. [↑](#footnote-ref-44)
45. 20% of carers who accessed ACE National projects gained part-time or full-time employment, or moved into self-employment, compared to 11% of carers who accessed the CReate project (Formby and Yeandle 2005). An evaluation of the People into Employment (PIE) project, which supported disabled people and carers into employment (see Chapter 3), indicated that 54% of carers who accessed the project, entered employment. Of the 86 carers surveyed in Wigfield and Marangozov’s (2014) study of effective employment support for carers, 64% reported they either remained in employment, returned to work, set up in self-employment or progressed into training or further education. 24% of carers who accessed ACE National services progressed in training or education and 9% commenced volunteering) (Yeandle and Formby 2005). [↑](#footnote-ref-45)
46. The CwC programme, on the other hand, was often effective at producing results for their target groups of carers, especially BAME carers (Buckner and Yeandle 2011). Evidence from the CwC programme indicates that BAME carers and male carers were more likely to report improvements in the care they give than white carers and women. BAME carers were more likely to report that their communication with professionals and service providers had improved (Buckner and Yeandle, 2011). Female carers were more likely than men were, however, to report improvements regarding their health and well-being (Buckner and Yeandle 2011). [↑](#footnote-ref-46)
47. Carers were asked to answer questions on a scale from 1 to 5: Has today’s workshop met your learning expectation? Overall, how would you rate the workshop? And would you recommend this workshop to others? [↑](#footnote-ref-47)
48. The number of carers tracked who set up in self-employment was high as a new member of CReate project staff who had enterprise and self-employment expertise was recruited a couple of months prior to the data collection period. Before her appointment, carers seeking to pursue self-employment were referred to a partner organisation. [↑](#footnote-ref-48)
49. Those claiming certain benefits can apply for New Enterprise Allowance, which provides money and support to help set up in self-employment or expand an existing business and is administered by Jobcentre Plus (DWP 2017). [↑](#footnote-ref-49)
50. The Carer’s Small Grant Scheme (now called the Carer’s Wellbeing Grant) provided one-off payments to carers of £200 to contribute to their health and well-being. [↑](#footnote-ref-50)
51. See Chapter 2, 2.2 for further discussion on carer-friendly workplaces. [↑](#footnote-ref-51)
52. Princess Anne visited Carers’ Resource as she is a patron of Carers Trust. The Director of Carers’ Resource stated in conversation that she aimed to use the visit as an opportunity to invite employers to Carers’ Resource offices and encourage them of the business benefits of supporting carers in the workplace. [↑](#footnote-ref-52)
53. See Chapter 3, 3.3 for full discussion of policy implementation and an ethic of care. [↑](#footnote-ref-53)
54. Carol reported in conversation this was because she did not feel confident using a computer and did not know how to search for or apply for jobs online. [↑](#footnote-ref-54)
55. Evidence from two interviews with Clare, informal conversations and observations of services accessed is drawn on. [↑](#footnote-ref-55)
56. The CReate project manager indicated in conversation that the funding for laptops had previously been secured from a national careers advice organisation which offered one-off grants to support local employment support projects. [↑](#footnote-ref-56)
57. See Chapter 3, 3.4 for full discussion regarding definition of partnership working and an ethic of care. [↑](#footnote-ref-57)
58. The casework team provide support for people in their caring role [↑](#footnote-ref-58)
59. Data is drawn from two interviews, observation of services Barbara accessed and informal conversations. [↑](#footnote-ref-59)
60. The DWP has been encouraging voluntary organisations to provide Work Clubs to ‘use local knowledge and resources to help unemployed people in their communities’ (DWP 2013) and they were initially a Big Society initiative (Crisp 2015). [↑](#footnote-ref-60)
61. Ex-offenders, those with health problems, those with disabilities and older people often face significant barriers to returning to work (HoCWPC 2016; Burke et al 2013; Loretto and White 2006). [↑](#footnote-ref-61)
62. See Chapter 3, 3.6 for full discussion of the definition of social inclusion. [↑](#footnote-ref-62)
63. Data is drawn from an interview with Carol, observation of services she accessed and informal conversations. [↑](#footnote-ref-63)
64. Evidence is drawn from observations of training sessions and the pop-up shop, conversations with CReate project staff and carers who participated. [↑](#footnote-ref-64)
65. The 2008 National Carers’ Strategy stated that £800,000 would be allocated to the DWP to provide employment support for carers through Jobcentre Plus (HM Government 2008). [↑](#footnote-ref-65)
66. Voluntary organisations in some other local authority areas such as York and Surrey (visited during PhD research) are funded through health and social budgets to deliver employment support for carers. [↑](#footnote-ref-66)
67. The Integrated Carers Service is the name of the service and contract for carer support services in Bradford, which Carers’ Resource deliver, examined further in Section 8.3. [↑](#footnote-ref-67)
68. According to the CReate project manager, this was to ensure that undertaking the evaluation would not detract from service delivery. [↑](#footnote-ref-68)
69. Although CReate project staff did meet their BIG Lottery fund targets despite high staff turnover. See Chapter 5, Table 5.8 [↑](#footnote-ref-69)
70. [↑](#footnote-ref-70)