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The Impact of Time on Home Care for Older Adults: Tensions and Challenges in Ireland

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Abstract:

This article explores perceptions of time reported by service users, family carers, care workers, nurses, social workers and agency managers across home support services for older adults in Ireland. The findings are organised around: time spent waiting for care; time spent ‘processing’ care across primary and secondary care boundaries; time and person-centred care; and time, technology and communication. Time emerges as a highly problematic aspect of all processes and structures around formal home care, suggesting that addressing issues around time is central to resolving systemic challenges. Greater flexibility in time allocation and effective communication among stakeholders could improve experiences of care time.

Key words:

Time; care; older people; Ireland

Introduction

Despite being one of the youngest in Europe, the population of Ireland is ageing rapidly, rate of growth being most notable in the number of people aged 85 years and over (Nolan et al, 2014). The majority of older people wish to age in their own homes within an age-friendly environment (WHO, 2016). The care context greatly affects how care is provided and organised (Stacey, 2016). The organisation of care time in a home setting is very different from how time is organised in an institutional care setting (Martin-Matthews, 2010; Sims-Gould and Martin-Matthews, 2010a). Lack of sufficient care time and lack of continuity of care over time can generate major challenges both for the older person and for the care system. For instance, allocating insufficient time to provide social care in the home may be the defining factor in the transfer from home to acute hospital or long-term institutional care. Many of the challenges to providing quality home care services may be ameliorated by effective use of time and other resources (DOHC, 2001).

Time is one of the most critical issues in quality of home care services (Rubery et al, 2015); in waiting list management (Raymond et al, 2016); in systems that use casual, part-time and zero-hour contracts (Baines, 2006; Burrowes, 2015), episodic working (Supiot et al, 2015), and time specified visits to service users (Bee et al, 2008). However, there is a dearth of research examining time from a multi-stakeholder perspective, that is to say, how the management of time affects health and social care workers, family carers, home care agencies and service users. This article considers time in the delivery of home care for older adults in Ireland from a multi-stakeholder perspective.

Context of home care services in Ireland: unregulated and fragmented

Publicly-funded health and personal social services in Ireland are delivered through a myriad of separate and often complex structures resulting in fragmentation at the point of care. The Health Services Executive (HSE) Primary Care Division provides community health services to older adults including nursing, physiotherapy, occupational therapy, speech and language therapy, palliative care and social inclusion services (HSE, 2017). General Practitioners (GPs) are independently contracted members of primary care teams (PCTs) providing care to older adults living locally (DOH, 2015). Long-term care services in Ireland are provided by the HSE Social Care Division, which funds residential placements in nursing homes (through the Nursing Home Support Scheme, NHSS) and Home Support Services which are frequently referred to as Home Help and Home Care Packages (HCPs) (HSE, 2018)

In recent years, pressure to control the costs of care has resulted in the outsourcing of HSE-funded home care services to a highly competitive market vying to secure HSE tenders (MRCI, 2015). Lack of statutory entitlement to services and absence of regulation have led to an uneven distribution of home care services, significant waiting times and growth in the private sector (HIQA, 2017; Care Alliance Ireland, 2018). Growth in the number of private sector providers - which cannot be accurately estimated due to the lack of licensing laws - has resulted in a multiplicity of care agencies employing increasing numbers of care workers, many of whom are not employed on proper contracts (MRCI, 2015).

Quality care requires investment of time and is defined by the HSE as person-centred, effective, safe care that seeks to identify and take opportunities for supporting health and wellbeing (HSE, 2016). Policy documents recommend effective use of time through implementation of electronic solutions and timely access to, and discharge from services while closely monitoring overtime pay costs (HSE, 2018). However, as our findings demonstrate, sustaining a person-centred approach within the current fragmented and marketised culture of home care presents challenges in relation to the time apportioned to provide individualised care and the time to co-ordinate that care.

Time and home care

The care journey commences with the identification of need by older persons or by care professionals. Matching identified needs with relevant support services and implementing a person-centred model of care across the many health and social care structures presents challenges. Home care provider organisations funded under the Social Care Division operate care services differently to the HSE directly employed carers' services. Under the outsourced model, agencies operate within a time-limited and time-monitored framework using strict work scheduling to focus paid work hours at high demand where time is the key unit of account (Rubery et al, 2015). Time affects the quality and cost of service provision, the skills deployed and the scheduling of work (Cooke et al, 2015). These home care organisations manage staff time using schedules as the primary control mechanism. The schedule acts as a form of work intensification, where the pace of work is monitored remotely through verifications submitted by the worker to electronic monitoring systems (Baines and van den Broek, 2016). These systems do not reward or recognise work-related time between periods of high or direct customer demand (Rubery et al, 2015, p. 754), for example, time spent in transit.

The use of controlled care-time, especially the use of 15- or 30-minute slots for care delivery (Leonard Cheshire Disability, 2013) requires much greater focus on from staff than full-time flexible hours. Under such circumstances, home care workers' time becomes focused on care as a tightly defined, task-based commodity (Bolton and Wibberley, 2014). Time is also fundamental in shaping the employment and client relationships due to the restricted working-time schedules (Cloutier et al, 2015).

Without sufficient time to provide the care required, domiciliary carers are faced with the problem of having to decide what care can actually be provided to which client (Bolton and Wibberley, 2014; Donnelly, 2015). Often they also end up performing care tasks outside of their working hours (Sinclair et al, 2000; Cuban, 2013).

Time is a particularly salient factor in personal care services, as these are co-produced with care recipients (and, where available, their family carers) in real time (Martin-Matthews, 2010; Sims-Gould and Martin-Matthews, 2010b). In social care, if the service user is not actively engaged with the carer in a trusting relationship, his or her particular needs may not be identified (Aronson and Neysmith, 1996). Care-giving encompasses skills, knowledge, time, and a relationship with the care recipient (Hermans and Mastel-Smith, 2012). The need for these expands in the presence of chronic or progressive illnesses - such as dementia - to allow for the quality and length of time needed to build a trusting relationship and to provide care that may be unpredictable and complex, requiring a more flexible approach (Hajek, 2015). Successful care-giving is underpinned by the skill of gaining access to the older person's environment and building trusting relationships – processes that take considerable time and skill (Cloutier et al, 2015; Martin-Matthews and Cloutier, 2018). Understanding that care-giving time in the home environment is more complex and unpredictable than in a more regulated environment, such as a nursing home, where standard routines are in place and the carers are on site, is fundamental to the delivery of home care.

The purpose of this article is to explore perceptions of time as reported by service users, formal and informal carers and professionals such as nurses, doctors, physiotherapists, social workers and care agency managers across the continuum of care experience in Ireland. How do these diverse actors in the realm of home care perceive time, and what can we learn from their experiences of time in care?

The study

The material reported here was taken from [*anonymised*] project titled [*anonymised*]. The [*anonymised*] project seeks to respond to the needs of the growing ageing populations in Europe by improving the accessibility and responsiveness of social care services [*anonymised*]. The project aims to address gaps in the area of social services by introducing [*anonymised*]. The data analysed here pertain to first and second stage in the project, conducted in February-October 2018, to understand the experiences and expectations of key stakeholder groups in the area of home care for older adults.

Research methods

We employed the Grounded Theory method to investigate various stakeholders' experiences of home care in the Dublin area. Grounded Theory studies maintain a high level of openness to novel and unexpected findings in the process of enquiring into experiences and processes related to the topic under investigation (Sbaraini et al, 2011; *Author's own*, 2018). Accordingly, we sought to learn from participants' experiences of services and their views on home care, through focus groups and interviews. Ethical approval was obtained from a university ethics committee [*anonymised*] in December 2017. Informed consent was given by all participants and pseudonyms have been used in the data extracts below.

When planning the composition of the focus groups, the research team agreed on the importance of incorporating a diverse range of older adults' services across health and wellbeing, primary and secondary care, rehabilitation and reablement services delivered in the community and in older adults' own homes. As the study progressed, theoretical sampling processes were utilised to fill in categories that emerged from ongoing analysis of the data. The study involved a total of 105 participants who took part in 21 focus groups and three in-depth interviews between February and June 2018.

The number of participants in each focus group ranged from three to seven, the typical number of participants being four. Interviews were carried out where there were insurmountable difficulties in bringing a larger group together (two family carers with limited time) and two senior policy makers who were more available in an individual interview context. The ages of the older people we talked with ranged from 65 to 99. Focus group discussions and interviews lasted 60-90 minutes; all were audio-recorded, professionally transcribed verbatim, and anonymised. During the fieldwork, we wrote memos and field notes reflecting on what we had learned from the conversations. The memos contained the research team members' interpretations of the participants' experiences and were used to systematically question some of our pre-existing ideas, and to guide theoretical sampling that led to saturation of key emergent concepts.

In accordance with the aims of the wider project, a [*anonymised*] workshop was held in October 2018, using purposive sampling to recruit a sub-sample of participants from the focus groups stage. The aim of the workshop was to explore further the key themes that had emerged in the focus group discussions, particularly "time", "communication", "technology" and "building blocks" of the health and social care system. Six service users and 13 providers participated in the workshop.

We will now proceed to outlining our findings pertaining to one of the central categories that emerged through iterative data analysis, namely 'time'. The dataset is particularly rich for the purposes of interrogating 'time' from multiple viewpoints, those of both care recipients and various care providers, ranging from health care professionals to agency directors and care workers. We will also consider the workshop findings that centred on the concept of time.

Findings

The findings are presented in four sections representing central elements of the care experience from the perspective of both service users and service providers. These are: time spent waiting for and accepting care; time spent 'processing' care across primary and secondary care boundaries; time and person-centred care; and time, technology and effective communication.

Time spent waiting for and accepting care

Experiences of time spent searching for information on the availability of services, time spent accessing scarce services, and the length of time spent waiting for recommended services ranged from quiet desperation to indignation. One family member caring for a relative with dementia noted her trial-and-error experience in sourcing information on specialist services and concluded that she had found out about these "*almost by accident"* (Maureen – family carer). Further exploration of access to services in the follow-up workshop identified the shared view that there was no "*single source*" that would act as a conduit to information and services. However, there were individuals within the various services who went the extra mile to try to act as such conduits. For example, a care worker stated she was often asked where an older person could get a hearing test – she followed up on such request because she saw it as a need although it is not within the remit of her work (Mandy – care worker from a not-for-profit agency). The lack of more straightforward channels of information and access to services naturally added to the time older adults spent waiting for services.

Contributions from workshop participants on the re-imagining of a service that offered a person-centred approach included the wish for a *‘single source of provision’* of services under *‘one umbrella’*. Many felt that services had become so complicated that a dedicated role in the community was required whereby information and access to health and social services would be provided. A comment posted on the communal board during the workshop discussion suggested *‘A job position for one person to connect a lot of services’*. Participants also recommended re-introducing services that had been previously in place but had been removed such as community liaison services or discharge planning teams to support hospital discharge so that services were in place before a person arrived home from hospital (instead of having to wait for them).

Even when services are accessed, it can take time for the care recipient to accept the need for help and the invasion of privacy this might entail. The perceived blow to a person’s self-worth due to age-related decline and the subsequent acceptance of formal support into the home, a place to which they have an emotional attachment, is often a major adjustment. Invasion of privacy and of personal time was reported as a factor in accepting home supports, further complicated in the presence of a disability which might interfere with communication (such as hearing loss). The adjustment is often abruptly realised in association with a health event such as a fall or an injury in the home resulting in hospitalisation or as result of bereavement of a spouse or more gradually through decline in ability to manage daily tasks:

> *I was pretty adept having the odd little accident in the kitchen. And but I could still make a meal and then gradually you get careless, or whatever. You’re not as sharp as you were…It gives you a sense of insecurity, rather than security.* (Sean – older person)

Time is required for people to accept support services within and outside their home. Many older participants described experiencing *‘trepidation’* before joining a community group (day centre) as they themselves had not felt ‘*old enough*’ to be eligible or were unaware that they had reached a stage in their lives where they were at risk of loneliness and isolation and in need of support; it took time to adjust to the idea of themselves as home care or day centre users. However, once older adults were successfully encouraged to accept day care and other group supports they were happy with the social connection these services brought to their lives. As Andrew, comments:

> *And this place changed my life…because I’m in the house on my own. And that gets me out of the house…I’m mixing with people as well* (Andrew – older person).

Many older participants were referred to services by ‘social prescribers’ such as social workers, GPs and nurses, or by children and grandchildren who used the Internet to source services.

Time spent ‘processing’ care across primary and secondary care

The amount of time needed to facilitate hospital discharge was seen as frustrating by social workers who recounted their experiences of having to advocate for both their clients and against the waste of scarce resources as extended hospital stays are both expensive and can have adverse impacts on the older person. Social workers were aware that irrespective of the amount of time they invest in putting a case forward, they may not succeed in procuring access to timely home supports, particularly in cases where loneliness is the prime concern or where a person’s needs are primarily cognitive:

> *…it gets really tricky in accessing care for the people who are physically really good but cognitively not so good…if it doesn’t actually involve some sort of aspect of providing like physical kind of care it’s very, very difficult to get* (Karen – Hospital Social Worker).

Ideal home care services support older people to take control over their daily lives and over the formal social supports needed, and enable them to contribute to community life (NICE, 2016). However, a significant challenge for hospital outreach teams is discharging people with complex needs, and highlighting the growing need for more specialist continuing care services. Public health nurses reported their frustrations with the generic system when accepting older people home from hospital, identifying challenges to an integrated service when there are significant time delays in implementing recommended social supports at home and in the community. In addition to this, community nurses also have responsibility for populations of older people who self-refer, and have an expectation to access much-needed but scarce support services that should be delivered in a timely manner:

> *…when the patient comes home, there could be a delay of a couple of days. And they don't have any help and that's the difficulty and frustration. You don't know if you're going to get it or not…they're on a waiting list'.* (Emer - PHN)

Care workers described additional challenges in setting up home care in relation to time to implement safe care for people with complex needs when collaborating across primary and secondary care. This is compounded by the fact that although providing continuing care, care workers are not perceived as formal members of the Primary Care Team.

Time spent waiting for care, the often inadequate hours assigned, and the allocation of time for tasks within the home support bundle, generated much discussion. Nurses saw their primary responsibility in providing nursing care, in assessing and reviewing older people for home supports and providing some level of 'oversight' of the care planned and provided. The lack of integration across health and social care systems within the community presents challenges for nurses who wish to practise a person-centred care model. The continuing reliance on paper-based records in Ireland leads to what nurses in particular see as waste of their time and duplication of work. When applying for or revising home support hours, nurses have to furnish significant amounts of paperwork in the standard Common Summary Assessment Report (CSAR) form which they consider both unfit for the purpose of providing home care and wasteful of their working time:

> *The problem is, the CSAR form is like ten or eleven pages. Then of that form you do have to fill out a care plan…And what the family's involvement is. And so that's all writing* (Susan – PHN).

In addition, the nurses provide supplementary information (in the form of carefully crafted letters) to support a more person-centred approach and to boost their clients' chances of securing care, a task that adds significantly to their time. This form of advocating for their clients - while extremely time-consuming - is seen as essential to improve the older person's chances of receiving care in their own home.

***Time and person-centred care**: fragmented time and continuity in care*

Participants agreed that time should be at the heart of person-centred care. Most participants voiced concerns about the lack of flexibility and of continuity of care which impedes building of relationships between service users and providers. The use of zero-hour contracts and care workers lacking the power to organise their work was seen as a highly problematic from the point of view of sensible time management:

> *….then if a person [home care worker] says that they're going to have a slow day. They [should be able to] stay with [the care recipient]…and organise their hours around that. There [should be] flexibility within the carers' hours* (Jacinta – PHN).

Nurses likened the desirability of more flexible hours for care workers to the autonomy and flexibility of their own nursing role: '*Sometimes you might spend an hour and sometimes you mightn't have to spend that long at all'* (Emer - PHN). Flexibility in time use and schedules was also considered essential by *a* family member caring for a relative with Alzheimer's disease who stated that *'no matter how you plan your day it won't turn out that way'* (Maureen, family carer). Having the skill and the decision-making authority to estimate the amount of time needed to provide quality care at the point of care was seen as an effective use of care time for which carer workers themselves recognised the need as *"when it* comes *to care one size cannot fit all"* (Aisling – private agency carer). Both carers and older people relayed frustrations with episodic working (Supiot et al., 2015) requiring a rush from one house to the next to provide multiple short episodes of task-related care. One HSE (public sector) carer commented on her counterparts employed by private agencies:

> *They [private agency caregivers] clock in and they clock out…She was only here for about 10 or 15 minutes and she's running out the door* (Esther – HSE employed carer).

This lack of ‘quality’ time was reported as having an impact on the older person’s health and well-being and their perception of the quality of the relationship with the care-giver. Older adults who participated in the follow-up workshop, spoke about ‘*lonely time*’, feeling lonely and wishing for carers to spend more time with them. Many participants agreed that providing ‘companionship time’ should be part of the home care package. Care recipients often interpreted limited time allocated for home care such as the 30-minute visit as a lack of caring:

> *And she [an older person] told me that people that come to her for the half hours are very cold. But it’s not because they’re cold. It’s because they have a lot to do within that half hour* (Grainne – HSE employed carer).

The understanding of complex needs, distilled in the time and experience of caring, may present challenges if not recognised or valued by the care assessor or care giver, as one nurse commented:

> *…we had to get a different carer in. Because they were rushing with the personal care and he has Parkinson’s. So he couldn’t be rushed….I suppose it’s maintaining dignity...Not to be in a hurry.* (Emer – PHN).

The practice of scheduling and monitoring standard care time slots was considered as a barrier to effective and timely care-giving. Notwithstanding inter-individual differences in daily rhythm, many older people will need care at broadly similar times for instance on waking, at meal times and on retiring in the evenings, which puts pressure on care staff. Participants in the workshop referred to this phenomenon as the ‘*care rush’*. In combination with concerns around scheduling of care workers, this results in inappropriate timing of care or shorter episodes of home care at these peak times.

Agency managers expressed considerable empathy for carers tied to these time slots which their agencies implement; they also acknowledged that the focus should be on quality rather than monitoring time. Many of them attributed time-limited home visits to lack of capacity (shortage of workers). Public health nurses were particularly concerned at the lack of nursing oversight in the time-limited care provision in light of the ageing demographic, the prevalence of chronic disease, multi-morbidity and poly-pharmacy.

Continuity of care was an aspect of person-centred care that was discussed by many of the participants. Continuity was seen as central to building relationships and providing a sense of security and safety for the older person, and therefore as a priority in care-giving. One carer employed in the HSE for more than ten years described high-quality care as provision of *'continuity of care, needs-based and flexible'.* Time taken to understand a person's needs is recognised as fundamental to good care (Fazio et al, 2017). Caring relationships are built through the process of engagement which develops and deepens over time; unnecessary suffering may be caused by carers who are unable to encounter the person who is in their care (Svanstrom et al, 2013).

Carers working for agencies felt that insufficient time was allocated to nurture relationships, to promote health and well-being, to provide company and get to know the older person. This perception was shared by agency managers who expressed concerns over the impact of this on quality of care and dignity of care recipients, stating that "*This sense of continuity of care that everybody looks for, it doesn't exist…"* (Hugh - private agency manager). The HSE (directly employed) carer workers also valued time as essential to good care in order to build rapport and trusting relationships:

> *I feel that time, time is more important than anything else….Because you build up a rapport with your client over the years*… (Esther – HSE employed carer).

In contrast to home care where many older adults' experience was of discontinuous and fragmented care, participants attending day care facilities reported a more person-centred care model, as Imelda recalls:

> *And they look after everyone individually, you know, each person was looked after individually with their particular problem* (Imelda – older person).

The experience in these centres was of inclusive, holistic care and unhurried care. In these day centres, most staff are on full-time permanent contracts and therefore available to attend to the needs of older adults, creating a relaxed, unrushed and welcoming environment.

Time, technology and effective communication

Service providers identified issues relating to communication across primary and social care which were seen as wasteful of their time and which may pose risks. The main issues identified as interfering with timely care-giving were the lack of an integrated information system and the multiple and unnecessary stages in the communication channel between carers, nurses and managers. All of these brought about lack of real-time communication, affecting continuity and quality of care. Sharing information electronically within and across boundaries was universally seen as a prime way of saving time, creating efficiencies, and integrating primary and secondary care.

Embedding the care worker's role into the primary care nursing team would provide a direct line of management and save time. Carers who worked within this model (those employed by the HSE) reported that it increases their confidence and autonomy in the delivery of a person-centred model. Another example of time saved by collaborative working is a dedicated community multi-disciplinary team that provide services to a small group of older people using an electronic system for patient assessments. Participants in this group unanimously agreed that it has the potential to seamlessly integrate person-centred services and to improve older person's capacity for independence, thereby decreasing the time needed to share information and to provide continuing care services. Nurses argued their role has changed significantly since the introduction of the formal HCP system (now known as Home Supports): instead of spending time providing direct nursing care they now spend a lot of time mediating between older people, families and the Home Supports system and ever more time recording and reporting incidents.

Nurses considered that technology would provide a solution to bridge the gap in communication particularly in the case of vulnerable older adults or those needing simultaneous home supports and direct nursing interventions such as wound care or prevention of pressure injury. They identified the recording of duplicate information in generic patient assessments and in CSAR forms (both of which are provided and stored in paper-based format in filing cabinets needing manual retrieval) as a waste of their time which could be spent more effectively in direct patient care:

> *…you have to manually look, you can't type in the name to see was he in the service before…[a shared database or another mechanism for sharing information] would improve contact hours. Because you'd be able to do more work, if you…didn't have to go back to the office. And spend an hour, or two hours doing the paperwork that was involved.* (Jacinta – PHN).

Older people echoed the nurses' comments on the duplication of information in both primary and secondary care settings:

> *…a nurse would come in; it'd be the same thing over again. She'd want to know what I just told another nurse five minutes earlier* (Ethel – older person).

Issues for agency carers in relation to technology centred on the potential to save time by sharing information about care recipients' needs or changes in carers' work schedules on-the-go. Efficiencies created in the communication and sharing of information would provide for more person-centred care co-ordination, for example in the case of alerting a carer on the team to the fact that a care task had not been completed. Some of the care agencies have developed *ad hoc* responses in recent years by using standard apps to share information: *'so we created a WhatsApp group for each and every client'* (Aisling - private agency carer). However, such improvised solutions do not provide a link to primary care and therefore cannot safely share information with PCT members or local GPs.

The HSE has made a strategic decision to implement the Single Assessment Tool (SAT) based on InterRai which is to provide a comprehensive patient assessment for use across integrated services and to replace the CSAR form (HSE, 2018). Most service providers were positive about an integrated system, one that would enter and update basic demographic information. Others voiced concerns about the adaption of the SAT and the fear that it would waste rather than save time: "*running around with a Single Assessment tool…is going to be even more time consuming* (Siobhan – hospital social worker).

Discussion and conclusions

In light of the findings presented above, time emerges as a highly problematic aspect of processes around formal home care. Time passes as older adults search for information and wait for care services - and their condition often worsens due to the lack of more timely care provision. Once care needs are assessed and approved and a bundle of care is commissioned, time is rationed through allocation of short 'bursts' of care that may not respond effectively to the needs identified. Care workers (especially in the private and not-for-profit sectors) feel that they are under constant time pressure, and their managers empathise with this, yet appear powerless to do anything about it. Technology is considered as a potential solution to some problems around time but it is not yet widely available or used in Ireland, and there is complete absence of system-wide technologies that would connect for instance primary health care and social care providers. A multiplicity of actors in the home care realm therefore appear to be victims of time; quality and continuity of care suffer as there is a heavy turnover of home care staff, largely (but not exclusively) because of time pressures.

In what ways could 'reform of time' be conducive towards better quality care, and better quality employment in the care sector? From among the many possibilities that are too numerous to outline here, we identify some that are particularly important. Firstly, time spent accessing information on care services nationally and locally should be optimised for both users and providers of services. There is a multitude of sources that provide varying levels of information but no one single source is recognised as a national online or offline repository. Providing a physical space or hub offering online access to a dedicated platform with a seven day customer support service in a local environment such as a shopping centre or post office would provide a real-time exchange of information. The onus would be on a range of public and other relevant services to keep information in the national repository up to date and customer services personnel would support older adults and their informal carers to connect to services and be responsible for providing feedback on the accessibility, accuracy and detail of online content. Such a platform would pave the way for online conversations between service users and providers supporting older adults to embrace the digital environment and engage in future co-design of person-centred services.

Secondly, the time spent waiting for care should be reduced and older persons who are placed on waiting lists should be prioritised using assessment tools that are valid and reliable and prioritise both health and social care needs: independence, frailty, dementia, social inclusion and loneliness. Thirdly, there should be greater flexibility to organise the use of time in the delivery of person-centred care in concert with primary care teams to promote quality, safety and continuous evaluation and improvement of services. All of these changes could be to some extent facilitated by the use of technology (such as timelier applications that are shared across the hospital and community-based providers). However, deploying technology as *the* solution to issues around time use would be erroneous in a care system that struggles with more fundamental issues around resource allocation, first and foremost the allocation of time.

Based on findings from the workshop that followed the focus groups, we were able to ‘mine’ for some of the underlying factors that are making time problematic in the current care system. While time could be variously ‘rearranged’ through greater use of technology, it is unlikely that this alone would address the underlying issues that are systemic. Participants in the workshop spoke about the lack of proper training and qualifications required from carers, as an issue affecting how carers are perceived and how much they can be trusted. Better training, pay and job security, and greater autonomy for carers could potentially lead to increased job satisfaction, reduced staff turnover and more flexible use of time, helping to remedy some of the issues identified above. While more time, therefore, requires more investment into care services, there may be other ways of commissioning home care that could help to address the issues outlined in this article such as outcomes based commissioning, an emerging approach that changes the emphasis from time to outcomes (see for instance LGiU, 2016). To turn the old adage around - money is time - and as such, more considered expenditure, innovation and communication with multiple stakeholders is required to transform time in care.

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