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Emotional Intelligence, Trust, Dignity, Psychological Contract, and Staff Performance: An Exploratory Evaluation of UK's Migrant Domiciliary Care Workers Lived Experience

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Abstract

Due to the deteriorating care quality in the United Kingdom's (UK's) social care sector, we link managerial emotional intelligence, psychological contract, and care quality in the UK's domiciliary care sector. Based on in-depth semi-structured interviews with 44 migrant domiciliary care workers in London, we utilized a combination of interpretative phenomenological analysis and hermeneutic phenomenology to investigate our participants lived experiences through the lens of the psychological contract literature. We found that participants faced personal challenges, poor relationships with their managers, and workplace challenges including communication, other, time management, work-life-imbalance, and safety and well-being concerns, which combine to influence their psychological contracts. Unfortunately, participants were erroneously treated as a homogeneous group who require a standardized approach to managing and staffing, despite their heterogeneity. Based on the reciprocity in psychological contracts, we conclude that, for improved care quality, employers/managers must first fulfil their obligations in the psychological contract with individual employees. This is one of the pioneering efforts to examine the relationships between managerial emotional intelligence, trust, dignity, psychological contract, employees lived

experiences, and care quality of the UK's migrant domiciliary care workers.

Keywords: *Psychological Contract, Migrant Domiciliary Care Worker, Emotional Intelligence, Trust, Dignity, and Care Quality*

JEL Classification: I11, I18, J15, J28, J41, J81, M12

Introduction

This paper links psychological contract breaches in the United Kingdom's (UK's) domiciliary care sector to a lack of managerial emotional intelligence, lack of trust, lack of dignity, and the poor care quality in the sector. Due to skill shortages, excess workload, intense competition, and constant regulatory changes, employers and employees in the UK's social care services are constantly rethinking their mutual obligations. While the employees continually review what they are owed by their employer and what they owe their employer (i.e., their psychological contract), employers continuously renegotiate, alter, and even breach the employment contract to fit the changing business' needs. Researchers argue that psychological contract breaches are common in sectors with high migrant workers, especially, where the migrant workers' long-term job security can only be guaranteed via a certificate of sponsorship (CoS), and in return for absolute diligence and longer-term loyalty of the migrant worker (Lampridis and Billè, 2023; Quadery et al., 2020).

This is the case with the UK's social care sector, where the migrant domiciliary care worker must constantly meet very high job expectations to earn a CoS, and, thereafter, even higher expectations to keep it, otherwise, they could face an immediate deportation to their resource-constrained home countries. Consequently, the migrant domiciliary care worker must ignore any perceived psychological contract breach by their employers, otherwise they could face unfounded allegations by their employers. Yet there is still a lack of research examining the causes, extent, and the consequences of psychological contract breach in various occupational settings (Li and Dai, 2015), as the mainstream psychological contract literature focuses mainly on the blue-chip companies (Kutalua et al., 2020). We view this a significant omission in the theoretical development of the psychological contract literature, and which our research is set to address in the unique context of the migrant domiciliary care workers lived experience in the UK's social care sector.

Consistent with the UK's growing ageing population (McKenna et al., 2020), the domiciliary care sector is flourishing (Turnpenny and Hussein, 2021). But unlike the residential care settings, domiciliary care services are delivered in the clients' home, denying the care workers of supervisory and peer support services. Due to the nature of the tasks involved, the domiciliary care roles are mostly performed by migrant workers (Skills for Care, 2026; 2026a, 2026b) who face expensive visa renewal fees and immigration charges (Williams, 2012).

Consequently, a high rate of mental, physical, and emotional strain, anxiety, burnout, insomnia, depression, heart diseases (Hussein, 2018; Turnpenny and Hussein, 2021), turnover (Skills for Care, 2026a, 2026b) and even suicide (Cannings-John et al., 2023). Unfortunately, these migrant domiciliary care workers face limited career progression opportunity, poor working conditions,

and a lack of standardization of training and qualifications (House of Commons, 2023; Turnpenny and Hussein, 2021). Yet the migrant domiciliary care worker is willing to accept below the national minimum wage (Van Hooren, 2012; Da Roit and Weicht, 2013), and coupled with family pressures from their home countries, these add to their vulnerabilities (Hussein et al., 2011, Cunningham and James, 2014). These highlight the need for more research examining the working conditions, wellbeing, and psychological contract breach in the UK's social care sector.

Although the psychological contract has become a key focus of the management and employment literature, existing research on the psychological contract has focused mainly on the blue-chip companies and multinational corporations (MNCs). Consequently, we lack research with a more critical and discursive analysis on the psychological contract in other work settings. For instance, research examining psychological contract breach in the social care sector can challenge the dominant theoretical assumptions on psychological contracts and suggest a different research agenda to that which has dominated the existing debate in the psychological contract literature. Therefore, we call for a narrative approach to studying psychological contracts, which challenges the ideologically biased approach inherent in contemporary work and employment literature.

Our study makes five complementary but distinctive contributions to psychological contract literature. First, we attribute a high disregard for employees' wellbeing in the UK's social care sector to the poor care quality which has continuously tormented the sector in recent years, as poor care quality can signify a response to perceived violations of the psychological contract. For instance, researchers argue that a prevalence of psychological contract breach can cause a false impression that a breach occurred, even when an actual breach did not occur, due to a lack of trust and unmet expectations (Koomson, 2021; Lambert et al., 2020).

Earlier research also links the psychological contract to organizational citizenship behavior (OCB) (Kraak et al., 2020; Piccoli et al., 2017; Restubog et al., 2008). Second, we link a lack of trust to perceived job insecurity, and a consequent high turnover. Thirdly, despite the influence of cultural differences on perceptions (Gracia et al., 2015; Zagenczyk et al., 2015), we link trust, emotional intelligence, psychological contract, dignity, and care quality standard. Fourthly, drawing on the traditional input-output analysis theory, we argue that employers should only expect employees' fulfilment of their obligation if they themselves have fulfilled theirs. Finally, as we reaffirm reciprocity in psychological contracts, we argue psychological contract a key to understanding human behavior in organizations. Our study also offers managers a valuable framework for managing the employment relationship. This paper addresses the following research questions.

Research Questions

- How can empirical evidence help us to understand the UK's migrant domiciliary care workers lived experiences?
- How can such a data help us to link emotional intelligence, trust, dignity, psychological contract, and care quality in the UK's domiciliary care sector?

Literature Review

Theorizing the Psychological Contract

The psychological contract embodies an implicit and unwritten aspects of the employment pact (Haque & Oino, 2019; Haque et al., 2020) which underpins the employee's obligation to repay the employer's fulfilment (or lack of fulfilment) of their own part of the written contract (Larsman et al., 2024). The psychological contract not only brings into focus the responsibilities of the employer as well as the employee, but it also frames the lens of expectations between both parties, which underpins the social exchange relationship in an employment context (De Clercq et al., 2020). Researchers argue that the psychological contract can be breached and how the employee responds to this is determined by the leadership's emotional intelligence (Batool, 2013; Kobe et al., 2001) and employment relationship (Larsman et al., 2024; Parzefall and Coyle-Shapiro, 2011).

The traditional psychological contract typifies predictability, stability, job security, and developmental aspects of an employee's jobs as promised by the employing organization, which lured the employee to an organization (Raeder et al., 2012; Tipples and Verry, 2006; Saari and Koivunen, 2022). Unlike the legal and binding contract, which is formal, written, and enforceable, the psychological contract is informal and unwritten (Abela and Debono, 2019; Naidoo et al., 2019). As individuals' perceptions, interpretation, reasoning, and assessment of work situations are influenced by cultural values and mindset (Gracia et al., 2015; Zagenczyk et al., 2015), the psychological contract is individually held (Westwood et al., 2001). Researchers have also linked psychological contract fulfilment to lower levels of turnover intentions and higher levels of safety compliance behavior (Deas and Coetzee, 2020; Kraak et al., 2022). Therefore, there is the need to clarify the terms and conditions of the employment contract (Koomson, 2021), and for due consultation and clarity of communication prior to any change in the terms and conditions of an individual's employment contract.

Psychological Contract in UK's Domiciliary Care Sector

Representing nearly half of the social care jobs and workforce, the UK's domiciliary or home care workforce consists about 1.60 million staff (Skills for Care, 2026). Yet, this category of care workers suffers job insecurity, precarious employment practices, and with about half of them still on zero-hour contract. These situations constitute additional stress to the migrant domiciliary care worker (Ravalier et al., 2019), unlike the residential care workers (Hussein, 2018). These situations have increased the turnover rates within the sector and thus forced the government to add the care workers to the shortage occupation list in February 2022 (Home Office, 2023; Skills for Care, 2026).

Apart from delivering care services in clients' homes without team and peer support, researchers have found that the relational aspects of domiciliary care work also differ significantly from institutional forms of care work (Denton et al., 2002). Yet, in general, the care worker tends to be highly undervalued, under-appreciated and under-paid compared to other workers (Razavi and Staab, 2010; Williams, 2012; Daly, 2001). Consequently, the domiciliary care workers have often come from less well-off kinship or socially disadvantaged, poorer communities (Bolton and

Townson, 2018).

Furthermore, for employees to engage and commit their cognitive and emotional intelligence in their work, researchers argue that employers must first make the work psychologically meaningful, satisfying, rewarding, ennobling, and safe (Chaudhary and Panda, 2018). Handy et al., (2020) also found that exchanging [and fulfilling] promises and setting [and meeting] expectations as early as the recruitment stage, and throughout the stages of the employment lifecycle can help employees appreciate the reciprocity in their employment contract.

Similarly, Rousseau et al. (2018) proposed an all-embracing model of the psychological contract to include: Causes (organizational culture, HRM policies and practices, experience, expectations, and alternatives); Content (fairness, trust, and the delivery of the "deal"); and Consequences (job satisfaction, organizational commitment, sense of security, employment relations, motivation, organizational citizenship, absence, and intention to quit). Rousseau and colleagues further linked this to a more imaginative use of social exchange theory (p. 662). This highlights the role of HR in ensuring that all promises made on reward and benefits are reasonable (Carter et al., 2018), and fulfilled (Raeder et al., 2012). Yet, the stakeholders – the care recipients, the care workers, the union, recruitment agencies, the deploying organizations, the care managers, and the care quality commission – all have a critical role in shaping the care relationship, the working environment, the workers motivation, the psychological contract, and consequently, the quality of care (Folbre, 2006).

Research Methodology

Unlike most research on psychological contracts that have adopted a case study approach focusing on a specific organization, our participants were migrant domiciliary care workers from diverse care agencies within London. As we aim to deeply examine a range of complex psychological issues in their employment relationships, a qualitative approach is suitable (Coyne, 2008). Furthermore, due to the subjective nature of our findings (DiCicco-Bloom & Crabtree, 2006), a qualitative approach also provides us with the flexibility needed to unpack our participants lived experiences regarding contract violation (Guest et al., 2013).

The research adopted a purposive sampling approach to select our initial five respondents, who then, adopted a snowballing sampling to help us reach out to 39 others. Therefore, our sample size is forty-four participants. It was required of each participant that they have written and conversational competence in English, there was therefore no need for engaging interpreters. The primary data was obtained using a single open-ended interview question that encapsulated the research questions with participants telling their stories unhindered. Where necessary, follow-up questions were also introduced to generate richer insight. Consent was sought for the audio recording of the interviews, while participants were made aware that pseudo-names will be used for anonymity. The interviews were held physically in locations within London which were mutually agreed upon between the researchers and individual participants. They took an average of one hour per research participant.

Coding

To generate a rich set of qualitative data and to facilitate an extensive coding effort, a verbatim transcription was adopted, where we shifted back and forth between participants' responses and the authors' interpretation of their meanings. In our coding, the interpretative phenomenological analysis approach (IPA) was adopted, using a "bottom-up" approach, meaning that the researchers generate codes from the data, rather than using an already existing theory to identify codes that can be applied to collected data (Smith et al., 2009). First, was the hermeneutic stance which was based on inquiry and meaning making.

We read the interview transcripts a few times to familiarize ourselves with the texts, to identify the emerging themes, and to establish their recurring patterns. Consequently, based on their patterns, similarities, and differences, some of the themes were eventually grouped under much broader themes, which resulted in adjustments to the theme structure (Smith et al., 2009). It is worth pointing out that at this point the psychological contract types were not a subject of analysis, bearing in mind that the participants were not asked to narrate about their psychological contract types, although this was implied in their narratives.

Table I presents the recurring words, subthemes, and final themes that emerged from the interviews following a coding and theme-generation exercise.

Table 1: Coding and Theme Generation

Recurring words	**Sub-themes**	**Final Theme**
Language, Writing, Reading, Non-verbal, Body language, English, Gestures, write it down, Documentation, Speaking, Body map, Incident book, handover, Greet, Feedback	Interactions at work Document management Communication hitches Communication impediments	Challenges with communication
Culture, Values, Beliefs, Ethos, Customs, Ethics, Traditions, Religion, Different, Conflicting, Incompatible Race, Racist, Racial, Stereotype, Ethnic, Skin colour, Groups, Grouping, Discrimination, Different treatment, Indifference, Profiling, Abusive, Insulting, Bias, Black, White, Asian	Xenophobia Chauvinism Othering Identification Gender bias Racism Whiteness	Prejudice
Poor pay, Low pay, Travelling, no travelling allowance, Limited time, Hurried time, Transport, Covering, No leave, hours of work, No compensation, Zero hours, Zero-hour contract, Work life balance, Holiday, Rest, Recuperation, Exhaustion, Care-plan, Duty rota, Time sheet, Clock in, Clock-out, Double-ups, Lone working	Working terms and conditions Leave issues Zero-hour contracts Work life balance Fragmented time Service provision-related–time – Carer-related time	Time Constraints

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Fear over safety, safeguarding, DBS Check, workplace violence, fear of assault, criminal record, Police caution Biting, Spitting, Punching, Verbal abuse, Pushing, Bending, Back pain, Body aches, Hoisting, Manual handling	Carer safety Client safety Dangerous workplaces Lonely workspaces Occupational Health and Safety concerns	Safety Concerns

Issues identified across the themes	
Issue	**Description**
Workplace Challenges	Employer indifference, basic job-related training, NVQ qualifications, performance appraisal, staff development, career, progression, de-skilling, no time, poor work life balance, unpaid work, inadequate, lack of progression opportunities, accreditation challenges, little or no organizational support, HR policies, service user/client, care agency, service user/client's family, local authority, manager(s), supervisor(s), men suited for manual dexterity required, women for more 'feminine roles, highly gendered.
Personal Challenges	Immigration issues, culture shock, stressful work, demeaning, challenging, dangerous, unsafe practices, perseverance, low status, job insecurity, degrading, domestic issues in home country, misunderstood, perceptions about the role.

Source: authors' own illustration based on field data

Data Analysis

Due to the popularity of the IPA, especially in health psychology research (VanScoy and Evenstad, 2015), we adopted the IPA in analyzing our interview transcripts. Mhatre and Mehta (2023) also argue that the IPA has the potential to understand and uncover various phenomena within the HRM field. Understanding and uncovering participants' lived experiences are key in our research, as they are a minority group whose experiences could differ significantly from the majority, and as such can inform management decision-making. The double hermeneutic theoretical underpinning of IPA requires that we, first, make sense of the participants' narratives, then followed by a second-order analysis which was done by making sense of the participants' meaning-making process (Smith *et al.,* 2009). One challenge to the adoption of IPA for this research is the lack of software designed specifically for IPA analysis.

To address this research credibility, participants' narratives are presented using vignettes as participant emotions and silent moments also consisted of the data collected.

Data was further analyzed and interpreted in two stages: firstly, through an inductive approach where the key themes were drawn from the narratives in line with the first research question. This approach has helped us to make sense of our participant's behaviors, their complex experiences, perceptions, values, attitudes, and observations about their work and lives.

Secondly, we applied double hermeneutics, a deductive approach, where we subjected these experiences to psychological contract literature to examine the resulting psychological contract as

reflected in the parts of their answers that relate to our second research question. Being an IPA study, rather than being guided by a particular theory, we identified and interpreted our participants lived experiences through four psychological contract typologies – the transactional (Haque et al., 2020, relational (Middlemiss, 2011; Naidoo *et al.,* 2019), transitional (Aggarwal and Bhargava, 2009), and balanced (Rousseau, 2004). Table 2 illustrates the deductive interpretation of the themes and findings through the psychological contract lens to answer our second research question.

Table 2: Deductive Analysis of the Themes in Relation to the Psychological Contract

Themes	Description	Inferred Psychological Contract
Challenges with communication	Misinformation, Misunderstandings, Complications, Difficulties.	Transactional, Transitional
Prejudice	Feel demeaned, deflated, maltreated, labelled, misunderstood, unappreciated	Transactional, Transitional
Time Constraints	Inadequate, hurried, rushed, fragmented, a balancing act, inadequately compensated.	Transactional, Transitional
Safety concerns	Personal safety, client safety, injuries, risky, unsafe equipment, precarious workspaces, poor HR policies,	Transactional, Transitional

Source: field data

Findings and Discussions

Applying an iterative data interpretation approach, we utilized the four main themes with connected sub-themes. These main themes have not only provided us with deep insights into the domiciliary care workers lived experiences, but they are key in addressing our first research question. We also adopted an emic analysis to help us present our findings.

Communication Challenges

The excerpts below show some difficulties experienced by participants around communication. These include language - verbal (speaking) and non-verbal (signs, gestures, and facial expressions), writing, accents, comprehension, and parlance. Specifically, participants highlighted the importance of effective communication in performing their domiciliary and other forms of care work, as language is a key issue when communicating with clients, clients' families, other social care sector partners, and with their co-workers. Hence, miscommunication could lead to frustration, aggression, and poor interpersonal relations:

Migrant domiciliary care workers reported facing difficulties around communication in the course of their work. Being non-native English speakers, having different cultural orientations from both their clients and colleagues inadvertently affected effective communication.

These challenges include - oral (language, pronunciation), non-verbal (eye contact, touch, space, voice, body movements, and posture), and written (comprehension) as portrayed in the excerpts below.

"Though originally from Romania, I lived in Austria before coming to the UK, I speak German, so tend to first think in German before responding in English. If I do not know the English equivalent, I just utter it in German or Eastern Romanise and this annoys my clients…both my colleagues and clients automatically expect me to speak good English…and sometimes they are annoyed by my inability to speak fluently" (Male, Romanian participant).

"…the language barrier is a major factor. Even though I can speak English very well- I have a foreign accent and sometimes when I go to these elderly people's homes they struggle with my accent. Sometimes they ask me if I am communicating in English. Sometimes you must repeat yourself again and again so that they will understand you. During double-ups, colleagues sometimes mimic my pronunciation and accent. This makes me feel undervalued" (Male, Bangladeshi participant I).

"There is a problem when carers speak their native language and exhibit parts of their culture in the client's home. The first time I went to client X, his mother remarked, thank God the agency has finally brought someone who communicates in English, unlike the Eastern Europeans they have been sending. She explained that the barrier in communication used to irritate and frustrate both her (mother) and her son (client)" (Female, Kenyan participant I).

"A client's mother remarked that she was pleased that the agency had finally sent someone who communicates in English, unlike the previous Bengali and Eastern European language speakers. She expressed her displeasure about carers conversing in their mother tongue at work places. Speaking one's native language during double-ups among colleagues excludes the client during person-centered caregiving" (Female, Kenyan participant I).

Valitherm (2014) also argued that communication problems can create major issues at work, especially regarding interpersonal relationships. In the context of the migrant domiciliary care workers, such problems have also been found to affect their job satisfaction (House of Commons, 2023). It was established that similar to (Evans and Suklun, 2017) there can be communication barriers even between people speaking a similar language due to accents, speaking a different language compounded the problem (Valitherm, 2014).

Prejudice Othering

This theme links participants' recollections of critical incidents at work, including racial discrimination, gender bias, confrontational behaviors, and ethnic profiling with perceptions of others. In some accounts, participants also justified how their memories of poor treatment at work led them to recalcitrant behaviors at work:

"Being male and black, I face discrimination for two reasons, especially from female clients. It is not only from the white clients but even from Black descendants too. Maybe arising out of gender or cultural differences they are apprehensive about my suitability to perform their

care tasks. Some will ask questions like – Does the agency not have female carers? ...Others refuse me entry into their premises in which case I lose job hours and this hurts because I am on a zero-hour contract" (Male, Nigerian participant I).

"The Filipinos and Eastern Europeans think that they are better carers than others, due to their lighter skin colour. Unfortunately, some clients also give these people preferential treatment. This makes me angry" (Male, Nigerian participant II).

"I was once called a fat black cow with a black face. Other clients comment about my short kinky hair. I have been ordered to get out of some client houses! I think this has to do with my being a foreigner, a migrant, and a low-skilled worker. This hurts" (Female, Nigerian participant III).

Earlier studies have found that cultural values [as well as lived experiences] can influence individuals' prejudice, perception, interpretation, and reactions to workplace incidents (e.g., Gracia *et al.,* 2015; Westwood *et al.,* 2001; Zagenczyk *et al.,* 2015), which can impact the level of stress experienced by an individual. Yet workplace bullying, role ambiguity, and role conflict have also been classified as job stressors (Hauge, Skogstad & Einarsen, 2010).

Time Constraints

The next set of quotes show that despite spending longer hours commuting in between locations of several short jobs, participants are only paid from the time they clock in, till they clock out of the clients' homes. Yet participants highlighted that the time allocated to performing critical tasks such as feeding clients (some of whom with physical disabilities) is never enough.

Poor services provision-related time

"I suggest that CQC should inspect home care premises in a similar manner to which they inspect institutional settings. There may also need to be a review of the time and budget allocation for some clients. I feel sad when I notice that a good number of clients are allocated, for example, a 15-20-minute mealtime visit. I have worked in such shifts, where in 15 minutes you may not effectively feed a client, especially if they have difficulties in swallowing. Even though I sympathize, I have a call straight after this, so I am unable to extend my stay. What I do is that I feed the client until the lapse of time, any leftover food is put in the fridge or if the client can feed themselves, I leave them to complete after I am gone. Sometimes the client may ask me to bin the food and clean the plate before I take my leave. I feel very sorry" (Female, Romanian participant II).

''I feel that the contact time allocated to some clients is impractical. Balancing personal care and feeding tasks A 15-20 minute visit to feed a client with challenges in swallowing is not sufficient. Despite my empathy when I am unable to wait until they have finished eating so that I can clean the dishes. That I have another call immediately after this one necessitates that I leave in time. Some clients ask me to bin any uneaten food before I leave so that I can

clean the dishes before exiting. This really saddens me" (Female, Romanian participant II).

"It's like you will be moving up and down running helter-skelter like a headless chicken the whole day between client homes back and forth because there is no time allowance for travelling time, as travel time is neither factored nor paid for in most domiciliary care work. You may find yourself being busy for about 10 hours, but the take-home pay is only for the contact hours that you clocked in and out at the client's home and not the time spent commuting. This is very demoralizing. Even for those who drive, they must deal with the traffic, the parking charges, and parking spaces" (Male, Philippine participant I).

"The hectic schedule that care work involves compounded by travel time not being paid for is a challenge. For example, for a 10-hour up-and-down job run, the pay is for contact time only. Even for those who self-drive to work, they have to navigate through traffic and look for parking slots in between their job shifts" (Philippine participant I).

From the quotes above, the hours of care available to the clients are beyond the care worker's control as these are allocated through a needs assessment by the local authority, and even where there is privately paid care, the recipient can decide on the actual hours they will purchase from their caregiver, based on their estimations. Where there is a discrepancy between the actual hours needed and those paid for, then there are issues, as some necessary tasks may not be finished.

As highlighted in the above quotes, this could result in feelings of oppression on the part of the carer, while the care recipients may also feel that their care needs have not been met. Yet, travel allowance needs to be provided, whether in the form of paid transport allowance, official transportation to distant locations, or where the allocations of care visits do not allow for time to shuttle between one visit and the next even within the same locality, as the current situation affects the working experiences of the migrant domiciliary care workers.

Subjugation to the duty rota. Supremacy of the duty rota

For both service users and staff, how the scheduling of service delivery interfaces with their daily lives and personal commitments is of prime importance. The centrality of the rota and its use in managing and making sense of the fragmented time within domiciliary care is shown in the selected extracts:

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

"As an agency worker, I experienced a time when I was not allocated any shifts. To be considered for available shifts and particularly new care packages, my physical presence at

the agency's offices and canvassing were required" (Male, Romanian participant III).

"At times if you or your co-worker is late for a double-up assignment, some unscrupulous agency managers will ask you to get along with it as you await your partner or even to complete the assignment on your own. This is very dangerous because for example if the client needs to be hoisted, things can easily go wrong" (Female, Nigerian Participant IV).

"Agency managers are under pressure to ensure that there is no loss of contracted hours and therefore compelling the available onsite worker to commence care roles individually even when the double-up partner is late or unavailable, not factoring in the risks if anything went wrong for example during hoisting. If safeguarding complaints are instituted it would be the carer to face the consequences" (Female, Nigerian Participant IV).

The above set of quotes shows how service scheduling, allocation of shifts, and lack of managerial emotional intelligence influence the migrant domiciliary care workers lived experience, and thus their psychological contracts.

Prevalence of Zero-hour contracts

The next set of quotes shows that participants have varied perceptions of zero-hour contracts. While the employer-initiated zero-hour contracts were criticized, some of our participants believed that the opportunity to choose to work zero-hour is a form of flexible work, as these are beneficial to certain categories of workers, e.g., full-time students and those with caring responsibilities:

"I was not offered a contract. My job is purely zero contract hours. So, if I don't work - I don't get paid. My holidays were tricky also because you don't get paid for the holiday… 'This job is just a slave job' because when you come to think of it- how much is my salary, it is not even up to the London Living Wage. It is hand-to-mouth. So, by the time you do your expenses- pay your transport - you have little, or nothing left. So, it's a challenge on its own" (Male, Nigerian participant I).

''From the onset, I was not given an option about what sort of contract I preferred. I was placed on a zero hour contract. If not working, there is no pay. I am not paid for holidays. Any absence from duty is perhaps considered unpaid time off. I feel entrapped, as my salary is below the London minimum wage often. It is a life of from hand to mouth and therefore quite challenging" (Male, Nigerian participant I).

"I don't agree with a zero-hour contract. If you want to give me a 6-month or another fixed-term contract then do exactly that, but do not give me a zero-hour contract" (Female, Belize participant I).

"I do not advocate for zero-hour contracts. If you want to give me a time limited contract for example six months, then be forthright and do that! For God's sake do not offer me a zero-hour contract" (Female, Belize participant I).

"Many people have suffered over the years [due to zero-hour contract]*; you work, no holidays, no benefits, and if you are sick, you wait until you get better to resume work to start being paid for the hours you will now work"* (Male, Lithuanian participant I).

"Over the years zero-hour contracts have negatively affected many carers, they have no holiday pay, no benefits and even there is no sick pay. If one is sick they have to wait until they are well to commence paid employment"(Male, Lithuanian participant I).

"In these 6 years of my employment, I have never had any paid leave as I am working for my agency on a zero-hour contract. There is no clause about leave in my contract" (Female, Sierra Leonen participant I).

"During my 6 years of employment in agency domiciliary care work, I have never been paid for leave. My zero-hour contract has no provision for leave, so I cannot claim any entitlement" (Female, Sierra Leonen participant I).

"I work for an agency, and I work on a 6-day week zero-hours contract, so I do not qualify for paid leave, nor do I have time to rest or take a holiday as I desperately need every coin I make as a single mother with three kids" (Female, Latvian participant I).

"As an agency worker and working for 6 days a week on a zero-hour contract, I am told that I do not qualify for paid leave. Since I need to make my ends meet, I have to work all the hours given that I am a single mother with three kids" (Female, Latvian participant I).

"Now I have 2 weeks of paid leave in my current contract. It's because of the law, that's made, they must do this. Otherwise, I would still not be paid" (Male, Antiguan participant I).

"In compliance with the law, I am now given 2 weeks paid leave in my current contract. I am sure if it wasn't for fear of the law my employer would not yield"(Male, Antiguan participant I).

From the above set of quotes, it can be inferred that though the migrant workers are willing to accept low pay and difficult working conditions due to their circumstances (Cunningham and James, 2014), with zero-hour contracts, this neglected group of workers lack annual leave entitlement and other accruing employment benefits in an already marginalized social care sector (Hussein *et al.,* 2011). Although as can be seen above, there are few exceptions where the domiciliary carers were offered paid leave as per the statutory requirements, in a good number of cases, the employer devised a practice to ensure that the employees were offered intermittent work that fell out of the leave entitlement threshold.

Poor Work-life balance Discontent over Work-life balance

Most of our participants mentioned their inability to balance their work and personal lives, including a lack of time for rest and recuperation. This can lead to burnout, anger, high stress levels, dizziness, and other health issues, and thus recalcitrant behaviors both at work and other social settings:

> *"Throughout my 2 years of working within domiciliary care, I have not taken any holidays, it has been working and working to pay my tuition fees, to meet my accommodation and living expenses* [changes tone to almost a whisper]. *It is not easy to combine full-time studies and domiciliary care work and family life but then I need the money"* (Female, Tanzanian participant I).

> *"For the 2 years I have worked, I have never taken any holidays. I am a student and have to work to pay my fees, cover my living expenses and travel costs. Combining full-time studies and agency domiciliary care work and family life is a tall order. However, I need the money"* (Female, Tanzanian participant I).

> *"It is very hard to balance work and life because the hours that are offered are few and the pay is poor, Domiciliary care work is different from residential care, so I need to capitalize on the available hours to make ends meet"* (Female, Polish participant I).

> *"In light of the low pay, erratic and few contact hours offered, there is a clear distinction between domiciliary and residential care. I crisscross both to make my ends meet. When I am not working in one, I take on shifts in the other, essentially leading to overworking"* (Female, Polish participant I).

> *"On work-life balance* [giggles]. *I try, but with this work, it is very challenging you know. Especially with the shift patterns because I also work on alternate weekends. I rarely find my children awake by the time I get home in the evening"* (Female, Nigerian participant IV).

The participant below shows the effects of a lack of work-life balance and provides advice from their experience:

> *"Before you go into care, think carefully. Plan* [grimaces] *because if you don't plan, you could end up with no family, you just live all by yourself. It's partly your fault because you have been working too hard* [giggles] *to pay your bills, to meet your other needs but lose your family bond... For instance, all your kids will grow up and you won't be there to raise them because you have been working too hard. That's why I would say, before entering this kind of work, home care work, make sure you have a plan… otherwise your whole life sometimes could go past you, and you don't even know…"* (Male Antiguan participant I).

Although Guerrero and Herrbach (2008) argue that where the perceived contract is not fulfilled, it can harm both the individual and the organization, hence both parties must deliver what was promised. The above quotes also show that sometimes, frustration could arise from unmet expectations.

Safety and wellbeing Concerns

Safety concerns were also identified, which relate to the safety of the clients as well as the careers. For instance, participants reveal their concerns over unsafe working conditions, and the possibility of falling short of the legal requirements for the safeguarding of vulnerable persons and the repercussions to the carers' career and possible conviction if found guilty:

> *"When I was employed by my agency, I was given 3 days of training. My first assignment was to provide domestic housekeeping services for a female client. Health and safety matters had been introduced in the training, but it was majorly on the use of PPE and the body alarm if I am alone working. As I was hoovering the carpet, the client took a knife and wanted to stab me. I had not been briefed that she had behavioral problems, and I could not access her plan as I had only been verbally briefed by the agency on the assignment. I dodged the knife by quickly running away. I was shocked- I mean, I couldn't just – you know did not feel safe in that house. I left and informed my agency. But what did they say? They just said, ok. Do not go there again. And I later heard that she was taken to an institutional setting for mental health problems. I felt that the agency did not give me a proper brief on the job, and I could have been killed in the cause of duty"* (Female, Pakistani participant I).

> *"Sometimes when your co-worker is late during a double-up, some unscrupulous agency managers will ask you to commence the job as you await your colleague or promise to send cover, but they do not. In the end, you do the job solo to completion. This can be risky especially if there is moving and hoisting. If any harm happens then you are legally liable to CQC. Doing the work of two people alone also requires more time and I get late for the next shift"* (Female, Nigerian participant V).

Inadequate training, misinformation about the care plan, and compressed care visit time also lead to unsafe workplaces as exemplified through the narratives by the above respondents.

Overall, in conclusion, our findings established that negative workplace experiences and the domiciliary migrant workers' personal circumstances affect the quality of the services provided. It further shapes the type of psychological contract that the worker forms. Managerial and institutional support is a mitigating force in determining the quality of care. Figure 1 below encapsulates our findings.

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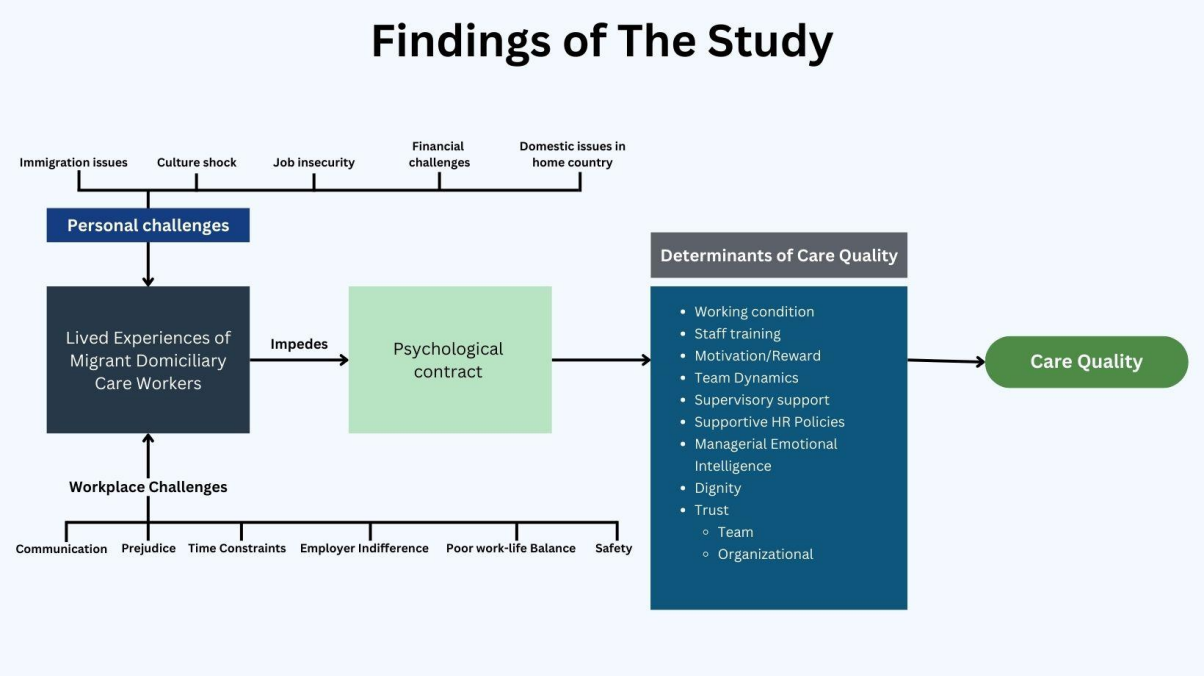

Figure1: *Findings of the study*
Source: Field data; developed by authors.

In the findings above, we have generated and presented empirical data to help us understand the UK's migrant domiciliary care workers lived experiences in addressing our first research question. It is the results of this that have been aptly presented in figure 1 and table 2, respectively. We argue through Figure 1 that there is a correlation between workplace, personal circumstances and organizational support and migrant domiciliary care workers' psychological contract. After a deviation from the expected behavior at work, employees perceive a breach of contract. Where there are perceptions of psychological contract breach, there is a breakdown in relations, whether the aggrieved employee leaves or exits, and it decreases productivity.

From available data the study established that many of the research participants inferred having experienced hardships at their place of work that made it difficult for the development of organizational citizenship behavior. Bearing in mind the contingent nature of migrant care work and the multiple interpretations of 'the employer'' it is imperative that all the actors in this sector play their part in ensuring the provision of quality care and sound employment practices. We pose a question "are vulnerable people taking care of vulnerable others?" if that be so then what can be done?

In addressing the second research question, this paper sought to link psychological contract breach in the UK's domiciliary care sector to a lack of managerial emotional intelligence, lack of trust, lack of dignity, and poor care quality in the sector. While Chambel et al. (2016) noted an increasing use of temporary agency workers (TAW), we have identified some of the key challenges facing this group of workers in the UK's domiciliary care sector. Some of these challenges include erroneously viewing participants as a homogeneous group, requiring a one-size-fits-all approach to managing and staffing, despite their heterogeneity. Communication challenges, which

participants highlighted how this affects their well-being, sense of self-worth, and the quality of care delivered. This is also consistent with the findings of Parzefall and Hakanen (2010).

We therefore highlight the need for effective staff training and development, alongside an effective employee support system. Although, the domiciliary care is classified as a low-skilled job, the limited training offered by the employment agencies is mostly too basic, inadequate, or too narrow, or lacks the sophistication to cover a wide range of job-related challenges faced by the migrant domiciliary care worker. Chambel et al. (2016) also highlighted the need for HR to fulfil its obligations on staff training, as a part of fulfillment of the employers' own psychological contract obligation.

Furthermore, episodic prejudice is another challenge experienced by the migrant domiciliary care workers. Despite such a negative experience, due to limited alternatives, participants must devise some coping mechanisms which may include recalcitrant behaviors such as verbal retaliation, working to specification, lack of discretionary effort just to mention a few which are indicative of a transactional-transitional contract. In addition, even where the care worker might be sympathetic with a client's situation and may want to offer additional care, which indicates a desire for a relational contract, the apportioned care time does not enable such as altruistic behavior. Researchers also argue that lack of fulfilment of an employer's obligation of the psychological contract affects employees' capacity to form a relational or balanced psychological contract (Tipples and Verry, 2006; Saari and Koivunen, 2022). For instance, an employee who has safety concerns whether they own or the client's will not perform their duties as expected, due to the risk of accidents or safety breaches that could affect care quality.

Moreover, any perception of animosity or abuse would make it difficult for a migrant worker to form a balanced or relational psychological contract. In fact, the description of 'migrant in the market model' (e.g., Hooren, 2012; Da Roit and Weicht, 2013) was upheld in our findings, e.g., as safety concerns, risks, and vulnerabilities of the migrant care workers were all highlighted. The transactional nature of the relationship between agency staff and their employer was evidenced by our participants' descriptions of how, due to time constraints, they drop in their time sheets at the office mailbox at the end of their work week, as failure to do so on time could cost them their weekly wage. In addition, the rampant use of texting to notify the agency about their availability for work epitomizes a transactional contract. Yet, the prevalence of zero hour contracts which is due to the economic hardship globally impacts the wellbeing of the migrant domiciliary care workers, who, like every other worker, need job security and a stable wage system, otherwise they are susceptible to developing a transactional - transitional contract, as they scout around for any available job offers (Lessner and Akdere, 2008; Cicellin et al., 2022).

Another notable characteristic of the migrant domiciliary care workers is that not much is promised to the worker at the point of entry into the employment relationship. Yet psychological contract fulfilment occurs when employees perceive that their employer has met promised obligations whilst a breach denotes a discrepancy between the assured and the met resulting in turnover intentions, turnover, and other undesirable employee attitudes (De Clercq et al., 2020).

Researchers also found that these negative aspects of the migrant domiciliary workers lived experiences result in low job satisfaction and a difficulty in forming a relational–balanced psychological contract (Turnley and Feldman, 2000). Yet the unequal power relations between the migrant domiciliary care worker, their employer, their client/client's family, and other social care partners hinder the development of a relational psychological contract. These aspects also hinder the care workers' willingness to work towards the achievement of the organization's goals, as organizational citizenship behaviors (OCBs) are affected (Amoah et al., 2021).

Moreover, in compliance with the home office immigration requirements most of our participants are on student visas, and as such, indicated that they are holding a transitional contract, which creates high levels of mistrust and uncertainty (e.g., Jepson and Rodwell, 2012), and thus could affect their capacity to fulfil their psychological contract obligations. For instance, this is evidenced in the interview quotes:

> *"The reason why I do not proudly wear my uniform and have to cover it up is that I do not see myself as doing this job all my life, I do it on and off". (Female, Ivoirian participant I).*
> *"I do this job as I wait to get my indefinite Leave to Remain in the UK. Also, I hope to commence my social work studies when all my children have reached the school age"* (Female, Cameroonian participant I).

Researchers (e.g., Cicellin et al., 2022) also argue that while the above situations can affect the employees' willingness to show affective commitment at work, the employers would find it difficult to build trust, to make meaningful investment into the employees' professional development, and thus the absence of a balanced psychological contract by both parties. Finally, a key feature of the psychological contract and the expectations that it encompasses is the way in which the expectations are influenced by management rhetoric (Grant, 1999, p.327).

Conclusion and Recommendations

Our study has revealed several key findings to suggest that the migrant domiciliary care workers experience racism, and have safety and economic concerns, all of which are inherently complex and concerning, and therefore require both further study and immediate action. These situations also limit migrant workers' capacity to build affective commitment or to fulfil their own part of the psychological contract obligations, as individuals can only build affective commitment if their physiological needs are met. This highlights the need to review the law around zero-hour contracts, while employers should also support the migrant workers, especially, during their adjustment phase, so they can develop a relational and balanced psychological contract.

Limitations of this study and future research directions

This paper does not seek to measure the psychological contract of the migrant domiciliary care workers by using the psychological inventory as developed by Rousseau (2001) and advanced by Rousseau et al. (2018). While this would have enhanced the current paper, given our participants'

circumstances, it would have been daunting to ask such direct questions to determine the type of psychological contract they held, or if there were instances where they breached their psychological contract. However, this provides an avenue for future research, as future researchers can focus on how HR practices such as recruitment, training, deployment, affect psychological contracts, by drawing from a range of sectors/organization in the UK.

To enhance a deeper understanding of the migrant domiciliary care workers in the UK we suggest that comparative studies be conducted between migrant and non-migrant domiciliary care workers. We recommend that future longitudinal research tracking psychological contract evolution over time be undertaken. This study focused on the subjective views of employees. There is a need for studies examining employer/manager perspectives to complement worker voices since the continued presence of migrants in the domiciliary care is a reality within the United Kingdom.

Contributions to knowledge

Earlier studies examining psychological contract breaches in the UK's health and social care sector had focused mainly on the nurses, therapists, and the residential care sector with only a brief mention of the domiciliary care sector. As one of the pioneering studies to address this research gap, the current paper specifically focuses on the migrant domiciliary care workers. Drawing from diverse nationalities and cultural settings, our paper builds on Ow Yong and Manthorpe (2016) study that focuses only on the lived experiences of 12 Indian migrant care workers in UK's residential homes. The diversities in our participants lived experiences will enrich the extant literature in a complementary but distinctive fashion.

Furthermore, the timing of our research is perfect – when the UK is facing a deep-rooted debate on immigration and the migrant workers contribution to the UK's post Brexit economy, especially, in the health and social care sector. By highlighting some of the taken-for-granted assumptions about migrant workers, their lived experiences, their significant contributions to the nation's socio-economic development, and how the country can maximize the benefits of employing this special group of workers, we offer contemporary knowledge that contributes to this debate.

Finally, in terms of our contribution to methodology, our blend of interpretative phenomenological analysis and hermeneutic phenomenology is distinct and will serve as a learning opportunity for less experienced and/or early career researchers.

Practical Implications

For enhanced care quality, we have highlighted the need for improved working conditions. We also stressed the need to review (and possibly, to abolish) the zero-hour contracts which have both financial and emotional/psychological implications for the migrant domiciliary care workers. Furthermore, care providers must improve their investment in staff training and development, including training on cultural awareness, so staff can benefit from tailored support to meet individual needs. In addition, the training should go beyond a superficial compliance with the Care Quality Commission (CQC) expectations but should encourage employees to show affective

commitment at work, and in turn will impact the quality of care provided. Trained staff should also be provided with the opportunity to utilize the skills learnt as a basis for progression/promotion.

Furthermore, this research has provided rich descriptions of the lived experiences of the migrant domiciliary care workers within London, whose stories serve as wakeup call for stakeholders in the UK's care provision, as such information highlights the need to review some of the existing policies. We have also highlighted the crucial role of HR in improving workplace resources and in effective recruitment, training, and deployment within the sector. Stakeholders that may find these findings useful include (but are never limited to) the Social Care Services Departments, Local Authorities across Britain, Home Care Associations, Trade Unions, Human Resource departments, and Organizational Development Specialists.

Furthermore, although the above challenges limit our participants' capacity to adjust, researchers have found cultural intelligence, technical Knowledge, Skills, Abilities and Other characteristics (KSAO), learning orientation, language skills, environmental factors (family, organizational, and interpersonal support), and training factors (content, process, and elements) key to migrant workers' capacity to adjust (Feitosa et al., 2014). Finally, access to sympathetic social support can have a significant positive impact on children and spouses' well-being, and thus the migrant workers' perception of the relocation decision, and thus, their psychological contract (Mutter, 2017).

Declaration

This manuscript is derived in part from a doctoral thesis of one of the authors.

Data Availability Statement

The authors confirm that the data supporting the findings of this study are available within the article [and/or] its supplementary materials.

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