

“Behind every visit is a life, my life”: Listening to home care recipients through oral history

By *DAVID PALMER**

Abstract

This article explores the lived experiences of older adults receiving domiciliary care in the London Borough of Bexley, UK, through a narrative oral history approach. Drawing on 26 in-depth interviews with individuals aged 55–102, the study highlights how care is understood, felt, and remembered by those at the receiving end of home-based support. Rather than treating care as a series of discrete tasks, participants framed it as a relational, emotional, and biographical encounter, shaped by memory, routine, loss, and the temporal rhythms of waiting and connection. Through richly textured accounts, the study demonstrates the profound impact of continuity, recognition, and emotional presence on the dignity and wellbeing of care recipients. It also reveals the fragility of trust when care is rushed, depersonalised, or poorly coordinated, particularly for those living alone or managing complex health needs. Participants described their homes not simply as sites of service delivery, but as spaces of identity, belonging, and contested autonomy, reshaped by the presence or absence of respectful, attuned care. Methodologically, the article advances oral history as a powerful and underused tool in ageing and social care research, illuminating

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experiential truths often missed by audit or survey-based methods. Empirically, it brings oral history into conversation with international literature on home care time, temporality, and emotion, showing how older service users themselves narrate the labour of waiting, relational work, and everyday negotiations of autonomy. The findings offer critical insights for care providers, commissioners, and policymakers, particularly in the context of integrated care reforms and the ethical imperatives of ageing in place. While grounded in a UK context, the study speaks to challenges facing ageing societies globally and offers transferable lessons on how relational, narrative-based approaches can inform more humane, person-centred home care models across diverse welfare systems. By placing the voices of seldom-heard care recipients at the centre, the article provides both a methodological contribution to oral history approaches in domiciliary care and an empirical contribution to understanding how older people experience “home care time,” continuity, and recognition.

Keywords: domiciliary care, older adults, oral history, ageing in place, personalisation, lived experience.

Introduction

Domiciliary care, care delivered in a person’s own home, is a vital part of the UK’s health and social care landscape. It is designed to promote independence, enable ageing in place, and reduce reliance on residential or hospital-based provision. The significance of home care has grown markedly in recent years in response to demographic ageing, shifting expectations around later life, and policy imperatives to reduce pressure on acute services (Age UK 2023; Skills for Care 2025). The Care Act 2014 marked a watershed in English adult social care, establishing a legal framework that prioritises wellbeing, personalisation, and prevention. Local authorities were tasked with assessing individual needs and supporting autonomy and choice. Yet many argue that the Act’s ambitions have not been fully realised in practice (Glasby 2020; Lymbery & Postle 2021). Chronic underfunding, workforce shortages, and fragmented commissioning have constrained the delivery of personalised and preventative care (The King’s Fund 2021).

The personalisation agenda, initially articulated in the 2007 policy initiative, Putting People First, has shaped subsequent reforms, encouraging direct payments, personal budgets, and user-led planning (Department of Health et al. 2007). However, critics warn that personalisation may entrench inequities, favouring those with the skills or social capital to navigate complex systems (Needham 2011; Glendinning 2012). Stevens et al. (2011) argue that without adequate support, personalisation risks becoming a form of withdrawal rather than empowerment. Market-driven commissioning has further complicated the picture. The majority of home care is now delivered by private or third-sector agencies contracted by local authorities. This model has been criticised for driving down pay, job security, and continuity of care (Rubery et al. 2015). Many care workers are employed on zero-hour contracts, often unpaid for travel time, despite delivering intimate, emotionally demanding work (Skills for Care 2025). Care Quality Commission (CQC) reports consistently highlight variability in visit timing, service quality, and training. While national strategies such as the Department of Health and Social Care's *People at the Heart of Care* white paper (2021) promote prevention, integration, and workforce development, implementation remains uneven. Integrated Care Systems (ICSs) and place-based partnerships aim to bridge health and social care silos, but questions remain about whether these frameworks adequately centre the voices of care recipients (NHS England 2023).

Much of the literature on domiciliary care focuses on system-level challenges, funding, staffing, and performance metrics. Far less attention has been paid to the lived experience of care recipients, particularly through the lens of narrative, memory, and identity. This study addresses that gap through an oral history approach that emphasises how older adults make sense of care within the context of their biographies, values, and everyday lives. While still emerging in health and care research, oral history has been championed by researchers such as Bornat (1989), Karpf (2018), Portelli (1991), and Palmer (2010) for its power to surface emotional truths and amplify marginalised voices. At the same time, the work sits within a longer tradition of reminiscence and life story approaches in gerontology and social work (Coleman 1986, 1989; Gibson 2011; Schweitzer 2007), which demonstrate how remembering and narrating past lives can sustain identity and self-worth in later life.

Oral history invites a fundamental reconsideration of what counts as evidence. It resists the reduction of care to transactional encounters, revealing instead how it is experienced through time, interwoven with memory, loss, and aspiration. As Riessman (2008) notes, narrative methods privilege meaning-making, allowing participants to communicate what matters most to them.

This study builds on that tradition to explore how individuals receiving home care in the London Borough of Bexley, UK, describe and interpret their experiences. It formed one component of a wider programme of commissioned work in the borough that sought to document and make visible the lived experiences of people receiving home-based support. As part of this programme, a public-facing exhibition was developed to bring residents' stories into dialogue with commissioners, providers, and community stakeholders (Palmer et al. 2021). The oral-history material presented in this article constituted a distinct strand within that broader initiative, designed to capture the depth, emotional nuance, and biographical texture of participants' accounts. The commission was intended to complement routine contract-monitoring and quality-assurance processes by providing an in-depth narrative understanding of how care was experienced at home. Findings were shared through reports and workshops with locally elected councillors, commissioners, senior managers, and members of the local Health Scrutiny Committee, and were further disseminated to residents through public exhibition talks and community-facing events.

This article makes three contributions to international ageing and home care literature. First, it offers an empirically rich account of how older adults narrate temporality, waiting, recognition and continuity in home care, extending international debates about home care time and autonomy. Second, it contributes methodologically by demonstrating how oral history and reminiscence traditions enable deeper access to emotional, biographical and memory-based aspects of care rarely captured in audit-led evaluations. Third, it provides a grounded, user-led perspective that can inform integrated care and ageing-in-place reforms in diverse welfare regimes.

Home Care Experience: International Literature and Key Debates

A growing international body of research has examined how home care is organised, experienced, and felt by older adults across different welfare regimes, offering important conceptual resources for understanding the temporal, relational and emotional dynamics identified in this study. While the Introduction situated the project within the UK policy landscape and outlined the rationale for an oral-history approach, it is equally important to locate the work within this broader literature. International studies, especially from Scandinavia and Canada, offer nuanced accounts of how tightly regulated care routines, procedural rigidity, digital scheduling systems, and market-driven reforms reshape the texture of everyday care encounters, influencing not only the experience of waiting and disruption but also older people's sense of autonomy and recognition. The following reviews this literature to establish the theoretical context against which the present study positions its empirical contribution.

Alongside these UK debates, an extensive international literature examines older people's experiences of receiving home care, particularly around time, temporality, and autonomy. Studies in Sweden, Denmark, Norway and Canada show how standardised, time-limited visits and digitally managed care rotas reconfigure both workers' and users' everyday lives (Bergschöld 2018; Cranford & Miller 2013; Palmqvist 2022; Tufte & Dahl 2016). Comparable evidence from Ireland highlights similar tensions: McDonald et al. (2019) demonstrate how rigid scheduling and temporal pressures shape older adults' sense of autonomy and recognition, while analyses from the Irish Longitudinal Study on Ageing (TILDA) show how patterns of fragmented and time-restricted home support affect older people's ability to sustain continuity and relational security (McCarrigle & Kenny 2020). Palmqvist's (2022) analysis of "waiting for home care" conceptualises waiting as a form of temporal governance, while Jönson et al. (2024) theorise a distinct logic of "home care time" structuring what can be done and felt within tightly scheduled visits. Swedish work on individualised home care services has also questioned whether promised autonomy and choice are realised in practice (Dunér et al. 2019a, 2019b), and recent writing highlights the relational work undertaken by older people themselves to sustain continuity and recognition

(Harnett et al. 2024). Together, this body of research establishes care as a situated, relational and temporally organised practice, rather than a simple bundle of standardised tasks.

In many of these studies, older people's voices are present but often mediated through worker-centred accounts or survey-based instruments. There remains comparatively less work that uses life story or oral history approaches to explore how home care recipients, in their own words, narrate the temporal, emotional and relational dimensions of care. This article addresses that gap and positions its empirical contribution precisely here. Rather than claiming novelty in arguing that care is relational, it shows how the concepts of home care time, waiting and relational work developed by others (Cranford & Miller 2013; Dunér et al. 2019a, 2019b; Jönson et al. 2024; Palmqvist 2022; Tufte & Dahl 2016) are experienced and articulated by older care recipients in one London (UK) local authority.

In recent years, a small but growing body of research has used visual, narrative, and participatory methods to highlight marginalised service-user perspectives (Calabria 2023; Palmer 2026; Schriff et al. 2013), although such approaches remain rare in studies of home care itself. Yet in both academic and policy domains, the voices of older people receiving home care continue to be marginal. They are frequently spoken about rather than listened to, particularly those with cognitive impairments, sensory disabilities, or from racialised communities (Moriarty & Manthorpe 2016). This study treats oral history not only as a method of documentation but as a practice of recognition and justice. Following Portelli (1991) and Thompson (2000), we position oral history as a means for older adults to narrate their lives on their own terms, creating a counter-archive that challenges the abstractions of policy and audit. In the context of home care, where small gestures carry enormous meaning, oral history captures the emotional texture of support: the weight of waiting, the importance of being remembered, and the loss or preservation of dignity.

The study was co-designed with local stakeholders and community members, embedding a participatory ethos throughout recruitment, interviewing, analysis, and dissemination. In this context, co-production refers to a collaborative process in which older adults with experience of home care, family carers, local authority practitioners, and voluntary-sector representatives acted as partners rather than consultees. Their involvement included shaping the interview guide, advising on accessible

and culturally sensitive language, discussing ethical considerations, and commenting on emergent themes and interpretations. This approach aligns with wider debates that understand co-production as the shared generation of knowledge and the joint shaping of service improvement, while also acknowledging, following Rose and Kalathil (2019), the persistent structural power imbalances that can constrain genuinely equal participation. Rather than claiming full parity, the study sought to create spaces where experiential insight could direct the research process, inform analytic decisions, and challenge professional or academic assumptions, particularly around risk, vulnerability, and the emotional realities of receiving care at home.

While grounded in the UK context, the themes explored in this study, emotional continuity, narrative dignity, and relational trust, resonate with global concerns about the quality, equity, and meaning of home-based support. Across Europe, North America, Australasia, and other ageing societies, governments are grappling with similar pressures: rising demand for care, constrained public budgets, workforce shortages, and a policy shift toward ageing in place.

Comparative research from different welfare regimes suggests that these pressures, together with market-based commissioning and standardisation, often produce convergent experiences of time scarcity, fragmentation, and emotional strain in home care, even where policy frameworks differ (Bergschöld 2018; Cranford & Miller 2013; Dunér et al. 2019a, 2019b; Jönson et al. 2024; McDonald et al. 2019; Palmqvist 2022; Tufte & Dahl 2016). Against this backdrop, the article has a clear aim: to use oral history to explore how older adults receiving domiciliary care narrate the temporal, emotional, and relational dimensions of support in their own homes, and to situate these accounts within international research on home care time, autonomy, and emotion. It examines how participants describe waiting for care, being visited, and receiving assistance; how they negotiate identity, dignity, and autonomy within these interactions; and how an oral-history, co-produced approach can extend and enrich existing international literature on older people's experiences of home care. Together, these questions clarify the article's empirical contribution and provide the analytic structure that follows.

Methods

Study Design

This study employed a qualitative, narrative methodology grounded in oral-history traditions. Oral history prioritises lived experience and the narrative voice, recovering forms of knowledge often absent from official records or policy discourse (Portelli 1991; Thompson 2000), and connects with long-established reminiscence and life-story approaches in gerontology that foreground memory, identity, and meaning in later life (Coleman 1986; Gibson 2011). In the context of domiciliary care, where service users are frequently marginalised, this approach enabled deep, experiential insight into how care is remembered, felt, and understood. The study was co-designed with local authority commissioners and community stakeholders in the London Borough of Bexley, UK.

The study formed part of a wider programme of commissioned work in the London Borough of Bexley that aimed to document and make visible the lived experiences of people receiving home-based support. Within this programme, a public-facing exhibition brought residents' stories into dialogue with commissioners, providers, and community stakeholders (Palmer et al. 2021). The oral-history material presented in this article constituted a distinct strand of the initiative, designed to capture the depth, emotional nuance, and biographical texture of participants' accounts. Commissioned to complement the local authority's routine monitoring, this strand generated a more contextual and narrative understanding of how home care was experienced in practice. Rather than focusing on performance metrics, it highlighted the dynamics of visits, relationships, and support from the perspective of those receiving care. Insights were fed back through written summaries, reflective sessions, and learning workshops to inform ongoing discussions among councillors, commissioners, and senior managers about service improvement and workforce development.

Participants and Recruitment

Twenty-six individuals aged between 55 and 102 participated in the study. All were receiving domiciliary care commissioned through the local authority. Participants were selected from a randomised list of

current service users. An invitation letter, participant information sheet, and consent form were mailed to over 400 individuals, of whom 26 provided written informed consent to take part. Where family members or informal advocates were present and contributed to the interview, their consent was also obtained.

Participation was voluntary, and care was taken to ensure that individuals had the capacity to consent and were not placed under any pressure. Participants were informed of their right to withdraw at any time. To protect anonymity, identifying details have been altered and pseudonyms used throughout. Data handling followed UK General Data Protection Regulation (GDPR) and Data Protection Act requirements. Participants received clear written and verbal information about the purposes of the research, the lawful basis for processing their data, and the secure storage and restricted access arrangements for audio files and transcripts. Audio recordings and transcripts were stored on encrypted drives accessible only to the research team. Participants could request deletion of their data at any point up to anonymised. These arrangements formed part of the initial ethical review and were revisited during the project to respond to any emerging concerns, in line with established oral-history and participatory research guidance (Portelli 1991; Rose & Kalathil 2019; Thompson 2000). analysis, and data retention periods were agreed with the commissioner in advance.

Interview Process

All interviews were conducted in participants' homes, often in the very rooms where care was received, allowing for a grounded, sensory-rich account of care environments. The interviews were open-ended and semi-structured. A thematic prompt guide was used to explore experiences of care routines, carer relationships, time and waiting, emotional and social wellbeing, and autonomy. However, participants were actively encouraged to digress, reflect, and direct the conversation in ways meaningful to them.

This narrative, participant-led approach positioned interviewees as active agents and storytellers. One participant remarked, *"Before we talk about the care, you should know who I was before this. Is that okay?"* Such reflections highlight how participants often situated current care experiences

within broader life histories, including work, migration, caregiving, illness, and family life.

Interviews lasted between 60 and 90 min. Nine involved family members who assisted with translation, advocacy, or relational context. All interviews were digitally recorded with consent and transcribed verbatim. Fieldnotes captured non-verbal cues, environmental context, and interviewer reflections.

Oral History as Methodology

Oral history, as both technique and philosophy, enabled the study to capture care not as a series of tasks, but as a deeply relational, affective, and temporal experience. Participants narrated routines and rituals, such as dressing or shaving, not only as physical acts but as affirmations of dignity and identity. For instance, one participant shared: *"I shave every morning, even if no one sees. It's for me."*

The method allowed emotional moments, silences, and memory work to surface organically. This alignment between oral history and reminiscence-based practices is particularly significant in ageing research, where narrative, memory and life-review processes play an important role in sustaining identity and psychological continuity in later life. Participants expressed frustration, grief, resilience, and humour. The dialogic nature of oral history meant meaning was co-produced between interviewer and participant. Interviewers listened attentively, followed emotional cues, and allowed space for memory, nostalgia, or quietness to emerge. As Riessman (2008) reminds us, narrative meaning is relational and culturally situated, not simply reported.

The home setting also anchored the method in embodied space. As one participant gestured to a worn armchair and said, *"This is where I wait. Always this chair. Because I need to see the door,"* the layered meanings of time, dependence, and anticipation became powerfully evident. These grounded, sensory moments are central to understanding the texture of care in everyday life.

Data Analysis

Transcripts were analysed using a modified version of the Framework Method (Ritchie & Spencer 1994), which combines systematic thematic

coding with inductive interpretation. A five-person team, including academic researchers, community partners, and individuals with lived experience, read the transcripts multiple times and collaboratively developed an initial coding framework. Codes were refined and grouped into thematic matrices to facilitate comparison within and across narratives.

Analysis was guided by three intersecting priorities: highlighting participants' own meanings and vocabulary; tracing structural and affective themes such as continuity, waiting, loneliness, and emotional labour; and situating individual narratives within wider policy and systemic contexts, including personalisation, market based commissioning, and integrated care. Regular team meetings supported critical reflection, intercoder consistency, and interpretive depth. The diversity of the research team enabled multiple perspectives on the data and strengthened analytical rigour.

In line with the co-productive ethos of the project, an advisory group including an older home care recipient and a family carer met at key stages to comment on emerging themes and language. Their feedback led, for example, to the adoption of participants' own terms such as "waiting" and "being known" as organising concepts in the analysis, and to minor revisions of how dependency and risk were described. This iterative dialogue reinforced the validity and relevance of the analytic framework.

Ethical and Methodological Reflections

Research with older adults in home settings requires ethical attentiveness. Interviews were paced according to participants' needs, and breaks were offered where required. Where participants became distressed or tearful, interviews were paused and emotional-support protocols implemented. At the close of each session, participants were given information on local advocacy, mental health, and wellbeing services.

Methodologically, oral history demands reflexivity. In keeping with relational models of community-based ethics, we treated ethical practice as an ongoing, context-sensitive process rather than a one-off procedural requirement, attending to "ethically important moments" as they emerged in the home setting (Palmer 2025). Interviews were co-constructed, with researchers acting not as passive observers but as engaged co-narrators. Choices about when to prompt, how to

interpret silence, and how to affirm emotional disclosures carry ethical and epistemological significance. The method respects not only what is said but how it is said, and what remains unsaid. In an era of heightened data-protection scrutiny, ethical reflexivity also extended to decisions about what material could be archived, how to balance participants' wish for their stories to be heard with privacy concerns, and when to withhold particularly identifying details. Some participants explicitly requested that certain stories not be shared beyond the research team; respecting these wishes is consistent with oral history's emphasis on narrative agency and participant control (Bornat 2001; Portelli 1991).

Limitations

This study is not intended to produce statistically generalisable findings. The sample size ($n = 26$) is modest and geographically concentrated in a single London borough. Participants were self-selecting and may reflect individuals more willing or able to narrate their experiences. Moreover, while the age range was broad, the sample may not fully represent the diversity of experiences across ethnicity, disability, or digital exclusion.

However, the value of this research lies precisely in its attention to individual voice. Each narrative offers a window into how care is experienced in time, space, and memory, insights rarely captured by audit tools or standardised metrics. While limited in scale, the findings reveal emotional and relational patterns that resonate far beyond individual cases. They speak to structural vulnerabilities in the care system and to the universal human need for recognition, connection, and dignity in later life. As with most qualitative and narrative research, the aim here is not statistical generalisability but analytical transferability. The experiential concepts identified, such as waiting, relational continuity, narrative dignity, and temporal disruption, can inform comparative analysis and be applied to understanding home care contexts beyond this specific locality. These findings therefore offer interpretive insights that may resonate across diverse welfare regimes and ageing-in-place initiatives internationally.

Findings: Oral Histories of Domiciliary Care in Bexley, UK

The thematic narrative analysis surfaced a nuanced and emotionally layered portrait of domiciliary care as experienced by older adults in Bexley, London, UK. Drawing on oral history interviews (Bornat 1989; Portelli 1991), the aim was not merely to extract data, but to co-produce situated accounts of care grounded in memory, emotion, and embodied experience. Participants narrated care not as a neutral service, but as a dynamic and relational encounter, shaped by temporality, loss, recognition, and the emotional geographies of the home. Each story represents more than an account of ageing or dependency; rather, it refracts broader themes of identity, dignity, vulnerability, and relational autonomy. Through these testimonies, the ways in which care is lived, negotiated, and at times resisted within the fragile intimacies of everyday life are illuminated.

Temporal Disruption, Anticipation, and the Rhythm of Waiting

For many participants, *time itself* was not simply a backdrop to care but a central component of how care was lived, negotiated, and emotionally absorbed. The anticipation of a visit created a distinctive temporal atmosphere in the home, one marked by suspension, vigilance, and the steady erosion of personal routine. Participants described mornings that were not structured by their own preferences but by the uncertain arrival of care workers, producing a form of temporal disruption that dominated the emotional landscape of the day.

Daniel (68), living with chronic illness, described his mornings as dictated not by personal choice but by uncertainty:

I sit in the chair and wait. Don't eat, don't sleep. You think: if I miss them, what then? What if I doze off? What if I'm in the toilet and they leave? You just stop living your mornin'...you, you, you hold your breath and wait.

This account powerfully illustrates the psychic toll of unpredictability. Waiting is no longer passive; it becomes an active state of vigilance, a suspension of normal life. For Daniel, the home becomes not a place of rest, but a temporal prison in which his autonomy is undermined by the spectre of a missed visit. The psychological weight of "missing the moment" transforms care

from comfort into emotional disruption. Elsie (78), who lives alone following the death of her husband, echoed this experience of temporal dislocation:

They say morning, but sometimes it's nearly lunchtime or maybe even later. You get cold sitting there in your nightie. You don't know when to move. You don't want to start anything. You feel silly just sitting there...but what else can you do young man?

Here, temporal ambiguity becomes physically and emotionally disorienting. The chill she describes is not merely environmental; it signifies abandonment and emotional exposure. Her routine is subordinated to an impersonal schedule, dissolving the structure and predictability that once gave her mornings coherence and dignity. Such experiences highlight how waiting is not simply a temporal inconvenience but an affective state that reshapes the emotional climate of the home, making the presence, or absence, of carers profoundly consequential for daily life.

Emotional Bonds, Recognition, and the Affective Labour of Care

Amid such disruptions, some participants described moments of meaningful connection. Where continuity existed, it provided not just familiarity, but emotional grounding. Mabel (91) shared a rich, evocative account of how her relationship with a long-term carer created a space of mutual care and recognition:

She knows what I like. Tea before the wash, always. She chats about her daughter...tells me about her school runs and her daft dog. I know her stories now, and she knows mine. It's not just wiping and washing. It's company. It's kindness. It's like having a niece who's come to see me every morning.

Mabel's account draws attention to the emotional labour that sits at the heart of good care work. The carer is not reduced to her function; she is a relational presence, a daily visitor who bridges the solitude of old age with shared stories and rituals. This bond humanises the routine of personal care and transforms the encounter from task-based assistance to co-produced emotional support. Through this intimacy, Mabel feels seen, not simply served. In stark contrast, Raj (84), a former civil servant, offered a strikingly different experience, one of depersonalisation and emotional erasure:

Some don't look at you. Just gloves on, quick wash, gone. No hello, no chat, nothing. Absolutely nothing. You feel like a body, not a, a, a person...like you're just one more job on a list. Yes, that's what I am...I'm a tick on a long list.

This moment of quiet indignation reveals the pain of being objectified in one's own home. Raj's narrative speaks to the existential shift from subject to object when care is delivered without recognition. The gloves and speed become symbols of distance, stripping the act of care of its emotional value. His past authority, his sense of self, becomes invisible in the face of task-oriented interactions.

The Home as Memory-Space and Site of Negotiated Identity

Beyond the emotional labour of visits, participants reflected on the ways home itself was reconfigured by the presence or absence of care. The domestic setting is not simply the site where care is delivered; it is a lived archive of identity, intimacy, and belonging. For Elsie (78), the front room, once a vibrant space of love and laughter, had taken on a radically different meaning in the context of receiving personal care:

This is my front room. This...where I danced with my husband right there (pointing). We used to move the table, put the radio on, and sway like we were still like young you know. Now... it's where I sit and wait and wait for someone to help me shower. Same room - very different life.

The juxtaposition is powerful and painful. The continuity of space highlights the discontinuity of experience. What was once filled with music and agency has become a stage for vulnerability and stillness. The narrators story reveals how care does not simply "happen" in the home, it reconfigures the home, transforming it from a sanctuary of the past into a holding space for dependency. For Veronica (86), the breach was not symbolic but felt physically and morally as a violation of personal space:

She just barged in. No knock, no hello...nothing. Straight through. It's not a ward...it's my house. You don't just walk in. You knock. You wait. You ask.

Her indignation is both personal and political. The language of “barged” and “not a ward” signals resistance to the creeping medicalisation of home. Veronica is asserting ownership, demanding the preservation of social rituals that affirm dignity and respect. Her response reminds us that the door, the act of knocking, is not trivial. It marks the boundary between self and system, between home and institution. These stories also surfaced deep tensions between past identity and present vulnerability. Daniel (68), reflecting on his current need for support, struggled with how care altered his self-image, particularly in relation to his former professional identity:

I used to be strong, mate. I taught at the college. Lectured in design. Now I ask someone to wipe my legs. Sometimes I still speak like I’m in a classroom...then I remember I’m not.

The contrast between past and present creates a form of temporal grief, a mourning not only for physical capability but for the status and symbolic power once held. Yet his continued use of a “lecturer’s voice” is also an act of quiet resistance, a refusal to relinquish identity in the face of functional need.

Loneliness, Attachment, and the Emotional Economy of Visits

For many participants, particularly those living alone, domiciliary care visits were more than service, they were fleeting islands of connection in otherwise vast oceans of silence. Raj (84), whose adult children live abroad, articulated this with quiet poignancy:

You count the minutes. Ten today. Fifteen if they stay for tea. Then silence. Again and again. After they go, it’s just the... ticking clock and the neighbour’s dog barking. You don’t want to get used to being alone...but you do.

Raj’s powerful testimony captures the brutal arithmetic of isolation. The visits, though brief, hold emotional weight far beyond their duration. Mabel (91), widowed and without children, described how she maintains emotional continuity with her late partner through daily rituals that now orbit around care visits:

...After she leaves, I talk to the bloody picture – yes, that one. I say what we had for lunch or dinner and so on. Or if the pudding was good. Silly, I know. But it keeps...I'm in the room... That's if. Talking to a picture.

Far from silly, Mabel's ritual is a quiet form of resilience. It reframes the care visit as a link in a longer emotional chain that connects the living to the lost. Sarah (55), who lives with progressive multiple sclerosis, described a stark shift in emotional climate when regular visits ceased during a staff shortage:

It went from someone coming every day to no... one for three. You start to talk to yourself just to hear a voice. You open the window... not for air, but in case someone walks by and says hello or even laughs. Now that would be special.

This account highlights the psychological dislocation that arises from abrupt breaks in care continuity. Her improvisations are a form of self-preservation in a context of emotional deprivation. Shifts in continuity, however, do more than disrupt daily routines; they unsettle the foundations of trust on which intimate care depends.

Skill, Safety, and the Fragile Trust of Care Encounters

These emotionally charged accounts of presence and absence also draw attention to the vital role of skill and sensitivity in establishing trust during routine care encounters. Veronica (86) described one such experience that left a lasting impression:

She explained every step...step by step...I'm going to help you sit, now I'll move the hoist, is that alright, love? – and she moved me so gently. I didn't feel rushed. I didn't feel like a job. She made me feel safe, like we were doing it together, completely together and all fine you know.

What matters is not just that the task was performed, but how it was performed. Trust here is built not through efficiency alone, but through shared rhythm, tone, and mutual pacing. In contrast, Sarah (55) recounted an incident that shook her sense of safety:

One girl, I don't know what age she was but didn't know how to get me out of bed. She tried, but she panicked. I slipped forward and screamed. She froze. I had to tell her to

stop. I was half-out of the chair, crying, and all I could think was: if I fall, I'll break. After that, I cancelled the extra visits. It's safer on my own I guess.

This moment is not just about inadequate training, but about the collapse of emotional trust. Care must feel safe to be accepted. When it fails, the risk is not only physical injury but psychological withdrawal. Yet even when trust is established, many participants described how the fragility of the formal system placed increasing pressure on unpaid family members to fill gaps, coordinate support, and hold the pieces together.

Informal Care, Invisible Labour, and the Limits of the System

In many narratives, formal care was scaffolded by unpaid family labour, often invisible, often essential. Mabel's daughter, Alice, described her hidden role as coordinator and crisis-manager:

They send rotas to Mum but not me. Couldn't make it up. She gets confused by them, bless her. Then they're late, or someone new turns up. I'm, I'm the one who gets the call. Mum says someone strange is at the door. I have to sort it all, but...I'm not on their books.

Alice's comment surfaces a structural blind spot. The system acknowledges the care recipient but not the familial infrastructure sustaining them. Similarly, Elsie's adult son described the toll of being an invisible carer:

It's a lifeline, sure. The carers help. But it's not a rest. I'm still on call every night. If she rings at 3 a.m., it's me. If the hoist jams, it's me. They don't see that part. They think care's just the visit. But it's the bit before, the bit after, the bit in between.

His repetition of *it's me* signals both commitment and exhaustion. The invisible labour of family members forms an emotional scaffolding for formal care, yet remains unrecognised in systems designed around scheduled visits and discrete tasks. Taken together, these oral histories offer a complex portrait of home care as a deeply emotional, negotiated, and relational practice. They reveal that trust is built not simply through consistency, but through tone, attentiveness, and mutual recognition. While participants valued practical support, what lingered most were the emotional textures of care, kindness, timing, presence, or the painful absence thereof.

Though grounded in a specific locality, these testimonies reflect wider pressures facing ageing populations globally: the erosion of relational care in market-driven systems, the invisibility of family carers, and the unmet emotional needs of those ageing in place. The home emerges here not only as a site of care delivery but as a contested space of memory, dignity, and identity. In listening closely to these stories, we are reminded that good care cannot be reduced to tasks alone. It is, at its heart, a shared human encounter, fragile, affective, and profoundly shaped by the small rituals of everyday life.

Discussion

The findings offer a vivid, deeply personal window into the lived realities of domiciliary care from the perspectives of older adults themselves, voices rarely highlighted in either policy consultations or empirical research. Through oral history, participants were able to narrate care as an emotional, embodied, and biographical experience. These accounts provide crucial counterpoints to dominant narratives in social care policy that often reduce care to metrics of efficiency, cost, or compliance.

A key insight emerging from this work is the centrality of relational continuity in enabling good care. Where the same carer visited regularly, participants such as Mabel and Raj experienced not only consistency, but a sense of recognition and dignity. These findings echo longstanding concerns raised by organisations such as the Care Quality Commission (2023), Skills for Care (2025), and The King's Fund (2021), which have highlighted the destabilising effects of rota variability and the erosion of trusted relationships in domiciliary care. In the context of current debates around workforce reform, including the Department of Health and Social Care (DHSC) adult social care workforce strategy, this research reinforces that emotional presence, reliability, and familiarity are as vital to quality as any technical skill.

Participants described how even small disruptions in staffing eroded confidence and created emotional uncertainty. The impact of such discontinuity extended beyond service reliability, it affected identity, safety, and peace of mind. For older people with limited mobility or sensory impairments, unfamiliar carers not only delayed routines but unsettled

their sense of trust. This emotional precarity is difficult to quantify, yet it shapes how recipients interpret the value and meaning of care. The testimonies speak directly to the policy aims of the Care Act 2014, which legislates for wellbeing, dignity, and person-centred care. However, the narratives reveal a persistent gap between these ambitions and the experience on the ground. Participants like Daniel and Elsie described a kind of suspended life, days governed not by autonomy but by waiting. The temporality of care, waiting, watching, rushing, became a mechanism through which marginalisation was felt.

In this respect, the study both confirms and extends international research on home care time and temporality. Palmqvist (2022) shows how older people in Swedish eldercare experience waiting as a form of temporal control, while Jönson et al. (2024) conceptualise “home care time” as a specific logic structuring what can be done within tightly scheduled visits. Tufte and Dahl (2016) and Bergschöld (2018) demonstrate how home care workers navigate conflicting demands of clock time, process time and digitalised scheduling. Our analysis contributes by emphasising how home care users themselves narrate these temporal tensions, not only as organisational dilemmas but as deeply felt experiences of suspension, vigilance and anticipatory anxiety. The imagery of “holding your breath,” “not starting anything,” and “sitting in the chair to watch the door” adds a biographical and affective dimension to existing conceptualisations of home care time.

The accounts also extend critiques of personalisation policy. While the vision of individual choice and control remains central to the social care narrative, researchers such as Needham (2011), Glendinning (2012), and Carr (2020) have shown that genuine personalisation requires far more than market mechanisms. It demands human connection, cultural sensitivity, narrative understanding, and system-wide flexibility capacities that cannot be engineered solely through budgets or consumer choice. Participants in this study framed care as a relationship built through time, trust, and biography, not a commodity to be purchased or arranged. Care was not experienced as a transaction but as a dynamic negotiation of vulnerability, recognition, and emotional safety.

These findings align with international research showing the limits of marketised personalisation. Swedish studies of individualised home

care reveal how formal opportunities for choice can mask significant constraints over timing, personnel, and continuity (Dunér et al. 2019a, 2019b). Comparable critiques have emerged in Ireland: McDonald et al. (2019) demonstrate how rigid scheduling and temporal pressures in Irish home care systems undermine autonomy, compress relational space, and intensify emotional strain, even when policy frameworks promise choice and flexibility. In both contexts, these insights suggest that personalised autonomy is difficult to achieve when continuity, familiarity, and relational depth are eroded by fragmented and time-pressured models of provision. The experiences described in this study therefore echo a wider international pattern: personalisation without continuity can easily drift into depersonalisation, reproducing the very forms of marginalisation it seeks to challenge.

Moreover, the findings support renewed policy interest in integrated and preventative models of care. The NHS Long Term Plan (2019) and the Health and Care Act (2022) seek to operationalise ICSs across England. These frameworks promise joined-up services across health, social care, and community sectors. Yet, as our findings reveal, integration is only meaningful if experienced at the point of delivery. The disconnect between formal carers and family carers, highlighted by Alice and others, reflects a failure to value the informal care economy and embed co-production in care planning. Policy rhetoric around community-based, preventative care must also confront the implications of rationed care hours, underpaid staff, and fragmented coordination. Without this, the burden shifts onto families, especially women and adult children, to fill systemic gaps. As Carers UK (2023) and the Office for National Statistics (2022) have shown, unpaid care underwrites much of adult social care provision, a trend that reinforces inequality and obscures structural neglect.

Participants' accounts point to loneliness and emotional isolation as pressing, yet routinely overlooked, aspects of domiciliary care. The Care Act 2014 makes explicit reference to social wellbeing, yet in practice, care packages prioritise physical support such as washing, dressing, medication, over emotional and social needs. As Mabel's and Raj's testimonies show, brief encounters with carers may be the only relational touchpoint in a day. In this light, every rushed visit represents a missed opportunity

for human contact. If policy aims to promote ageing in place with dignity, it must account for the emotional architecture of care.

Training and confidence, particularly in relation to safety and communication, are therefore crucial. While technical competence is essential, this study highlights the central role of “soft skills” such as empathy, clarity, and non-verbal cues, in shaping recipients’ sense of safety and respect. Participants trusted carers not just when procedures were followed, but when intentions were communicated and bodies were handled with care. Training standards must evolve to include relational, emotional, and narrative competencies, as advocated by NICE (2022). Recent work on the “relational work” undertaken by care users themselves (Harnett et al. 2024) also helps to contextualise our findings: participants described reassuring new staff, smoothing interactions, and downplaying their own fears to avoid being labelled “difficult.” Recognising this relational labour is important if integrated care is to become more than an organisational slogan.

Crucially, this study contributes methodologically by demonstrating the value of oral history within social care research. Whereas many evaluations rely on structured surveys or audit tools, oral history enables participants to narrate their experiences on their own terms. This approach surfaced memories, values, and cultural meanings that are rarely captured in policy evaluations, offering a more holistic and emotionally resonant lens on care, one that can complement conventional approaches to regulation, inspection, and commissioning. In doing so, the article situates itself within a long-standing tradition of oral history and reminiscence work with older people (Bornat 1989, 2001; Coleman 1986, 1989; Gibson 2011; Schweitzer 2007), while directing this tradition towards contemporary questions in domiciliary care and ICSs.

Empirically, the contribution is not to restate that care is relational, a point well established in the literature, but to show how older home care users’ own narratives of time, waiting, identity, and recognition can deepen and nuance international debates about home care time and person-centred care. As Bornat (1989, 2001), Karpf (2018), and Portelli (1991) argue, oral histories reveal not only what is remembered but *how* it is remembered. In this context, they also emphasise what is forgotten, sidelined, or excluded from dominant narratives about ageing, dependency,

and support. Listening closely to these stories challenges policymakers and practitioners to confront difficult truths about vulnerability, marginalisation, and the gradual erosion of personhood under bureaucratic pressures

In light of this, regulators such as the CQC might explore incorporating narrative interviews as part of inspection frameworks, moving beyond compliance to lived experience. Similarly, training providers and professional bodies could draw on oral histories to teach relational care skills, intersubjectivity, and cultural humility. For commissioners and planners, these narratives offer insight into what older adults actually value: continuity, warmth, conversation, and recognition.

Ultimately, this study suggests that to build better home care, we must listen more carefully, and more creatively, to those who receive it. Their stories do not ask for perfection, but for presence. Not for heroics, but for humanity. In the fragile space between need and support, a good carer brings not only help, but dignity. In their words, we find a blueprint for care systems that heal, rather than merely sustain. This is the core empirical contribution of the article: it offers detailed, co-produced narratives that show how international debates about time, personalisation and relational work are lived and negotiated in one local home care system, and what this means for policy aspirations around wellbeing and ageing in place. These findings therefore call for a profound reframing of what counts as quality, from punctuality and task delivery alone, to connection, trust, and narrative understanding. If the future of adult social care is to be truly person-centred, as both the Care Act and DHSC strategy envision, it must be built not only on metrics, but on memory, identity, and story.

Implications for International Research

The themes identified in this study, waiting, relational continuity, temporal vulnerability and narrative dignity, resonate with international literature on home care time, autonomy, and emotional labour across diverse welfare systems. Research from Scandinavia, Canada, Australia and continental Europe documents parallel tensions between standardisation, time scarcity, and the erosion of relational work in domiciliary care. By offering

a narrative, user-led perspective on these dynamics, the findings provide interpretive tools that can support comparative analysis of ageing in place and integrated care reforms globally. The concept of “home care time,” in particular, may offer a transferable analytical lens for understanding how older adults negotiate identity, autonomy and recognition within time-limited care encounters in different international contexts.

Conclusion

This study offers a rare and valuable insight into the everyday experiences of older adults receiving domiciliary care. Through an oral history methodology, we moved beyond conventional service evaluation to illuminate how care is lived, narrated, and remembered. Participants’ accounts revealed home care as a profoundly relational and biographical experience in which vulnerability, recognition, and dignity are negotiated on a daily basis. These narratives highlight the importance of emotional presence, familiarity, and responsiveness in shaping how older adults feel supported, valued, and able to sustain a sense of self.

The findings highlight that good care cannot be reduced to a sequence of tasks completed within rigid timeframes. As international research has long shown, care is a situated practice embedded in relationships, emotions, and temporal rhythms (Cranford & Miller 2013; Dunér et al. 2019a, 2019b; Harnett et al. 2024; Jönson et al. 2024; Palmqvist 2022). Our data expand this literature by showing how disruptions to continuity, rushed encounters, and unmet expectations of recognition are experienced by older care recipients as threats to dignity and identity. What mattered most was the presence of carers who knew their routines, remembered their stories, and recognised them as whole persons.

These insights challenge prevailing approaches to social care delivery. While the Care Act 2014, the People at the Heart of Care white paper, and ICSs emphasise personalisation, wellbeing, and co-production, participants’ accounts reveal a persistent gap between policy rhetoric and lived reality. Fragmented rotas, unpredictable timing, and staff turnover undermine the relational foundations on which meaningful care depends. The temporal dynamics of care, waiting, uncertainty, and hurried interactions, emerged as key indicators of systemic strain as well as emotional impact.

The study makes a dual contribution. Empirically, it demonstrates that relational continuity, narrative dignity, and emotional safety are central to the wellbeing of older adults receiving home care. Methodologically, it shows the value of oral history as a way of accessing the emotional and biographical dimensions of care that are often overlooked in audits, surveys, or performance metrics. By situating this work within the long-standing traditions of reminiscence and life-story research (Bornat 1989, 2001; Coleman 1986, 1989; Gibson 2011; Schweitzer 2007), the study illustrates how insights about memory, identity, and later life can inform contemporary debates about ageing in place and integrated care.

Although situated in a single London borough, the implications resonate beyond the UK. Across diverse welfare systems, including Sweden, Ireland, Canada, Australia, and Germany, similar pressures shape home care: rising demand, fragmented commissioning, market-driven priorities, and workforce shortages. International studies echo the challenges described here, highlighting the erosion of continuity, the undervaluing of relational labour, and the emotional vulnerability experienced by older people receiving home-based support (Bergschöld 2018; Cranford & Miller 2013; Dunér et al. 2019a, 2019b; McDonald et al. 2019; Palmqvist 2022; Tufte & Dahl 2016). Despite differing policy models, the need for care that is relational, respectful, and emotionally attuned appears universal.

Oral history itself has wider relevance for ageing and care research. It enables researchers and practitioners to move beyond administrative understandings of service delivery and engage directly with the lived, narrated experiences of older people. It has particular value for amplifying perspectives that are often marginalised, including those of individuals with cognitive impairments, communication difficulties, or from minority ethnic and linguistic communities. Oral history's emphasis on agency, meaning, and memory offers an important complement to dominant evaluative frameworks.

For policymakers and system designers, the lessons are clear. Investing in home care is not only a matter of resources or coverage; it is a question of values. If ageing in place is to be meaningful, systems must support care that is stable, relational, and grounded in everyday life. This requires recognising care workers as skilled professionals, creating conditions that enable continuity, embedding emotional and cultural competence in training, and acknowledging the vital contributions of unpaid carers.

Ultimately, this study affirms that care is co-created through presence, trust, and recognition. Behind every visit is a life, rich, complex, and deserving of more than efficiency. The testimonies shared by participants invite us to reimagine what good care looks and feels like, not only in the UK but across ageing societies worldwide. As demographic, economic, and cultural pressures reshape expectations of later life, these narratives offer both an ethical foundation and a practical guide.

Suggested Further Research

Future research should build on these insights in several ways. First, longitudinal oral history studies could explore how experiences of home care evolve over time, especially as needs change or cognitive impairment progresses. Second, comparative international research using similar narrative methodologies would deepen understanding of how different welfare models shape the temporal, emotional, and relational dynamics of care. Third, there is a need for participatory and co-produced research that centres the voices of groups often excluded from care debates, including people from minority ethnic communities and those living with dementia. Finally, integrating oral history into service design and evaluation processes could help professionals, commissioners, and policymakers attend more closely to the lived realities that underpin meaningful, person-centred care.

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