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Title: 'Managing Down': 'Pioneering' Practice and Professional Discretion in the South-West of England Care Homes during the Pandemic

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European Societies
https://doi.org/10.1162/EUSO.a.87

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European Societies
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'Managing Down': 'Pioneering' Practice and Professional Discretion in the South-West of England's Care Homes during the Pandemic

ABSTRACT

This qualitative study investigates how care homes in South-West England managed and responded to the everyday challenges of the COVID-19 pandemic. While many studies explore the impact of the pandemic on care home staff, residents, and families, limited research addresses care homes' experiences with filtering top-down rules and guidelines during 'uncertain times'. Drawing on the concept of street-level bureaucracy, this study examines how professionalism operates under crisis conditions and how it impacts discretion and organizational response within care homes. Based on fourteen semi-structured interviews with care home staff, including managers, analysis highlights care homes engaged in effective response mechanisms and developed innovative practices in response to the needs of staff, residents and their families by moving beyond the scope of established guidelines. The mobilization of professional discretion under crisis conditions by both care workers and managers centre around four key categories: strengthening infection control and prevention, promoting socialisation, enhanced communication and fostering intra- and inter-professional teamwork. *Pioneering,* which emerges as a common element across these categories, shapes care home workers and managers professional discretionary responses in relation to policy mediation and implementation during the pandemic. This study, thus, emphasises the ability of care home staff to take action and their resilience in facing pandemic-induced challenges.

Keywords: care homes, COVID-19, street-level bureaucracy, professional discretion, UK, online interviews

1. Introduction

The COVID-19 pandemic, starting in late February 2020 in the UK, placed a heavy burden on healthcare professionals and the care sector. Initial global findings indicate that almost half of the total COVID-19 fatalities in five European nations, including the UK, were concentrated among residents of care homes (Comas-Herrera et al., 2020). Existing studies (Daley et al., 2022; Hanna et al., 2022: Schultze et al., 2022; Titley et al., 2023) have investigated how severely care homes were affected by the COVID-19 pandemic. Care homes, with their frequent staff-resident interactions, mobility, and frequent contact with hospitals, are high-risk environments for infection spread, particularly due to the vulnerability of elderly residents (Guthrie et al., 2022). These pandemic-related challenges, coupled with pre-existing issues such as labour shortages in the care home workforce and funding challenges prevalent in care homes before the pandemic (Marshall et al., 2021), made the care home popluation highly susceptible to the COVID-19 infection and increased risk of resident mortality.

Researchers have examined the COVID-19 pandemic's effects on care home staff, residents, and families, including its impact on mental and physical health, as well as related policies (Grey et al., 2022; Ho et al., 2022; Paananen et al., 2021; Daly, 2020; Daly et al., 2022; Wilson et al., 2025). However, there has been limited research, focusing on care homes' experiences of overcoming everyday challenges of the pandemic (see Marshall et al., 2023). In our paper,

European Societies
https://doi.org/10.1162/EUSO.a.87

we focus on the practices of care home staff, including managers. Our focus on this group is significant, as work within care homes and/or nursing homes is often viewed as unskilled or undemanding, despite its complex nature (Carlson et al, 2014; Crozier and Atkinson, 2024; Kadri et al, 2018; Timonen and Lolich, 2019). Therefore, we, in this paper, ask: *What were the views of care home staff about COVID-19 policies and what was their experience of working within care homes during the pandemic?* In order to answer this question, we have employed, 'street-level bureaucracy (Lipsky, 2010) as a conceptual framework to understand the role of professional discretion (i.e., exercising autonomy in the interpretation and implementation of policies) in addressing and tackling numerous tensions (e.g., understaffing, the frequent changes in COVID-19 policies, keeping pace with the evolving phases of the pandemic) in care workers' day-to-day work during the pandemic. Previous studies in 'street-level bureaucracy' within social care settings, have largely focused on the practice of social workers (Evans, 2011, 2016; Higgs and Hafford-Letchfield, 2018; Lima-Silva et al, 2020; Nilson and Oliason, 2020), nurses or doctors (Dvorak et al, 2021; Hupe and Keiser, 2019) who have oversite of care home workers. Our study pays particular attention to care home workers themselves, the professional group who has most day-to-day contact with care home residents and their interactions with care home managers. Due to care workers historically being labelled 'unskilled workers' and managers being classified in managerial positions; they have not previously been viewed as 'street-level bureaucrats'. Our focus on care home workers and managers explores how they employ professionalism under crisis conditions and how they interpretate and implement COVID-19 whilst exercising discretion.

2. Care Home Staff as Street-Level Bureaucrats in Times of Pandemic

Street-level bureaucracy, coined by Lipsky (1976, 2010), is an interdisciplinary concept that has been extensively investigated across various fields. It includes but is not limited to social care and healthcare scholarship and has also been applied to other areas including education, law enforcement and environmental regulation (see, Chang and Brewer, 2023). Street-level bureaucrats are described as "public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work" (Lipsky, 2010: 3). In this respect, frontline workers such as teachers, healthcare professionals, police officers, social workers, judges, public lawyers and other public employees are categorized as street-level bureaucrats (Lipsky, 1976, 2010). Street-level bureaucrats operate within highly regulated and fragmented systems. This situation represents the two sides of the same coin. On the one hand, street-level bureaucrats are often required to execute policy agendas marked by conflicting or ambiguous elements in situations where resources are insufficient and consequently, they struggle to discharge the responsibility for their clients and/or citizens owing to the mismatch between inadequate resources and demands and/or requests. On the other hand, "as a professional who has the discretion to identify, apply and, if necessary, adapt public responses to the context brought by his/her client, the street-level bureaucrat becomes an important agent in understanding the materialization of public policy" (Macena and Oliveira, 2022: 1). Thus, street-level bureaucrats, when necessary, employ their own coping strategies to manage varying tensions in their daily work (Lipsky, 1976; Tummers et al., 2015). Put differently, street-level bureaucrats can introduce their own response mechanisms and execute necessary actions in line with their institutional and organizational logics in response to the needs or requirements of clients and/or citizens.

European Societies
https://doi.org/10.1162/EUSO.a.87

Research on social care and healthcare increasingly applies the concept of street-level bureaucracy (Allen, Griffiths and Lyne, 2004; Ellis, 2011; Finlay and Sandall, 2009; Macena and Oliveira, 2022). Existing studies explore "the routines and simplifications" employed by frontline workers in social care and healthcare "to process people"; the coping strategies they use to address work-related challenges while meeting client and/or citizen needs; and their role in influencing policy implications (Finlay and Sandall, 2009: 1229).

While numerous studies examine frontline workers as street-level bureaucrats, less research focuses on care home workers in this context, who fall within the orbit of social care (Higgs and Hafford-Letchfield, 2018; Nordh and Nedlund, 2017). The existing studies highlight the complex dynamics of policy implementation in adult social care. Evans (2011) highlights the vital role of discretion in social services, emphasizing its significance at all levels of the organizational hierarchy, especially in complex settings with ambiguous or conflicting policy goals. This emphasizes the critical role of both frontline social workers and managers in mediating policies. For that reason, Evans (2011) critically examines Lipsky's account of discretion, highlighting a lack of consideration for the role of professionalism. He argues that professionalism significantly shapes the daily interactions between frontline social workers and managers, thereby influencing the concept of discretion. He further argues that managers should be considered part of the conceptualisation of the 'street-level' as they may either perform coordination roles involving direct interaction with citizens or shape the discretion of street-level bureaucrats, thus indirectly affecting their interactions. It is also noted that the majority of frontline supervisors were previously street-level bureaucrats who advanced to their current supervisory positions (Evans, 2016). This shared professional background helps bureaucrats and frontline supervisors connect and find common ground. Managers leverage their experience to create an organizational ethos that aligns with the needs and concerns of frontline workers. It is, thus, crucial to understand the discretion of not only front-line workers, but also managers as key policy actors as their decisions significantly shape the context in which front-line discretion is exercised.

Relatedly, Hupe and Keiser (2019) emphasize the importance of studying first-line supervisors (nurses) as street-level bureaucrats, noting their significant influence in shaping organizational policy. These supervisors play a crucial role in crafting implementation patterns by filtering and interpreting rules from top-level managers before conveying them to street-level bureaucrats, effectively managing the flow of information and directives downward. As well as *'managing downward'* (channelling information from top-level managers to street-level bureaucrats), *'managing upward'* (communicating information from street-level bureaucrats to top-level managers) and *'managing outward'* (relaying information from external actors and networks) are identified as mechanisms through which first-line supervisors can contribute to co-make policy. Supervisors communicate rules to frontline staff in five distinct ways: a) *Passing:* directly conveying formal rules to subordinates without modification: b) *Strengthening*: including additional rules or guidelines before communicating them to the staff; c) *Translating:* prioritizing certain rules over others: d) *Buffering:* selectively blocking or omitting certain rules, choosing not to pass them on to the staff; and e) *Countering:* actively challenging rules when communicating with organizational superiors, particularly when they disagree with those rules.

European Societies
https://doi.org/10.1162/EUSO.a.87

Equally important, a contextualised understanding of how discretion operates within specific micro-contexts (Ellis, 2011) becomes even more relevant in the context of atypical events like the pandemic, which remains underexplored, despite an extant literature on street-level bureaucracy in 'normal times.' Discretion is multilayered and involves various stakeholders across different levels, thereby obscuring the lines of accountability in decision-making processes and adding complexity to a comprehensive understanding of how policy is enacted (Scourfield, 2015). Similarly, Brodkin (2011) argues that policy is routinely defined and redefined at the street level by frontline workers whose discretion is informed by how policy operates in practice, particularly when they are under pressure.

Public health literature increasingly focuses on the role of care professionals in facilitating the implementation of COVID-19 policies; their decision-making process in uncertainty; and their coping strategies in response to needs of clients and/or citizens in times of pandemic (Munkeby, Bratberg and Devik, 2023; Lima-Silva et al., 2020; Rauhaus, 2022). These studies highlight care professionals' capacity to adopt innovative responses to pandemic-related challenges as well as identifying implementation difficulties associated with new pandemic-related policies. However, reviews of street-level bureaucracy research have noted some limitations within the current literature. Chang and Brewer (2023) note that research focusing on the use of discretion has mainly focused on social service settings, law enforcement or employment. We would concur with these findings but would add that research in social care settings have largely focused on decision-making by those with an oversite role (most notably social workers, nurses or doctors) (Higgs and Hafford-Letchfield, 2018; Nord and Neuland, 2017; Munkeby et al, 2023). Very few research studies focus on the role of both care home workers and managers as street-level bureaucrats and their use of professional discretion within the context of the COVID-19 pandemic. For instance, Nilsson and Olaison (2020) analysed care managers' strategies to conduct needs assessment meetings with the elderly via phone due to the visiting restrictions in Sweden, but only make passing reference to street level bureaucracy. Whilst not mentioning Lipsky's theories, Marshall et al. (2023) studied how care home managers had to adopt their working patterns within and across organisational and regulatory boundaries of practice in England during the second wave of the pandemic, highlighting that uncertain situations and ambiguous policies provided care home managers with the opportunities to adopt different tactics in decision-making processes on the basis of their discretion such as employing very pragmatic and reflexive policy practices for the sake of the welfare of both residents and staff members. In summary, the actions of those workers and managers with most day-to-day contact with users of social care services remains overlooked. This leaves a significant gap in how our understanding of street-level bureaucracy functions in care home settings.

Despite the extant focus on street-level bureaucracy, particularly on the discretion exercised by ground-level workers during normal times (Ellis, 2014; Evans, 2013), the role of professionalism in filtering and interpreting of top-down rules and guidelines during 'uncertain times' has been largely overlooked in the literature (Northdurfter and Herman, 2018). Here, discretion refers to "the freedom in exercising one's work role" (Evans, 2010: 11) and professionalism should be understood not as a status or a set of qualifications, but professional manners that shape how individuals perform their work and exercise discretion in line with their institutional and organizational logics (Evans, 2010; 2011). Our study, thus, takes an

European Societies
https://doi.org/10.1162/EUSO.a.87

original approach through examining the retrospective accounts of both frontline workers (i.e., care home staff) and first-line supervisors (i.e., care home managers) regarding 'crisis management'. We unpack how professional discretion operates under crisis conditions and how it impacts on organizational response within care homes, especially given the importance of collective organisational practices (Berlin et al., 2022) in both healthcare and social care settings. By bringing together two concepts, our analysis indicates how various forms of *'managing down'* (Hupe and Keiser, 2019*)* interact with the professional discretionary responses (Evans, 2010) of care homes in relation to policy mediation and implementation during the pandemic. In doing so, we address the gap in knowledge as to how both care home workers and managers use professional discretion and how theories of street-level bureaucracy can add to this understanding.

Acknowledging five distinct ways of the communication of rules and practices by supervisors for frontline staff, our findings point out an additional way to *managing down*, which we term *pioneering*. *Pioneering* refers to the act of bringing innovative perspectives to rules or practices while communicating them. It is usually accompanied by either 'passing', 'strengthening', 'translating', 'buffering', and 'countering', but in addition to trimming, revising, selectively blocking, or challenging rules or practices, *pioneering* enables frontline workers and supervisors to forge new approaches and/or methods that establish a foundation for others to follow and build upon in similar situations.

3. Care Homes in England in Times of Pandemic

Although care homes in England were heavily affected by COVID-19, they were not prioritized in the Government's agenda until mid-April 2020. During the pandemic, care homes experienced a disproportionate impact, with estimated cases between March and June 2020 being 13 times higher than in the community (Dutey-Magni et al., 2021). The first wave of the pandemic lasted from March to June 2020, with the UK pandemic action plan announced on March 3rd, 2020. In this plan, there was only one reference to the adult social care system (DHSC, 2020). Surprisingly, care homes were depicted as social settings with a low risk of COVID-19 until guidance on minimising transmission risks in residential settings, including care homes, was issued on 13 March 2020 (Daly, 2020). Instead of shutting down care homes, they were advised not to allow visitors who felt unwell or showed COVID-19 symptoms (Daly, 2020). The first 'lockdown policy' was announced on March 23rd, 2020, without any specific reference to the situation in care homes, followed by the announcement of the *Coronavirus Act 2020* on March 25th, 2020. A crucial change was made to local authorities' social care duties, allowing them to prioritize addressing the most urgent and acute needs such as depleted workforce or heightened demand (Social Care Institute for Excellence, 2022).

In April 2020, the UK's *Department of Health and Social Care* (DHSC) initially released a detailed action plan for adult social care in England, outlining how to manage COVID-19 in care homes and setting out visiting restrictions. The action plan for adult social care was centred around four pillars: (1) controlling the spread of infection in care settings; (2) supporting the workforce; (3) supporting independence, supporting people at the end of their lives and responding to individual needs; and (4) supporting local authorities and the providers of care. One of the milestones of the April 2020 guidance was the policy, which required testing of all

European Societies
https://doi.org/10.1162/EUSO.a.87

residents in the care homes where COVID-19 patients were being discharged which was not the case before (DHSC, 2020). Another milestone, announced on April 18th, 2020, was to allocate extra £1.6 billion to local authorities across England to support and expand their response capacity to COVID-19 across the services they delivered including adult social care (DHSC, 2020). This indicated a change in the government's 'downgrading approach' to care homes (Daly, 2020).

Following the Government's policy change toward care homes, further policies were introduced particularly concerning adult social care: in May 2020, a new £600 million *Infection Control Fund* was pledged to address the transmission of COVID-19 within care homes. This new fund contributed to broader assistance for both residents and staff in care homes. A mental health and well-being package was launched to support care home workers through the outbreak. Testing policy was revised to offer tests to all care home staff and residents in England regardless of being symptomatic or asymptomatic. Additionally, a new digital portal was launched for care homes to request test kits. Furthermore, each care home in England was assigned a clinical lead to provide direct care for residents. This new fund also aimed at regulating the social care workforce recruitment by introducing the new national social care recruitment campaign (i.e., deployment of nurse returners to care homes, adopting 'train the trainers' approach) (DHSC, 2020). In October 2020, further support from the National Health Service was introduced, necessitating that every care home appoints a designated health professional as their main point of contact. In December 2020, visitor lateral flow test trials were conducted, later adopted nationwide in March 2021 as a PCR testing alternative (Marshall et al., 2023).

Having outlined all policy developments, it would be safe to say that the government's initial plan, announced in earlier March, concentrated on sustaining care delivery in the face of an outbreak rather than prevention (Daly, 2020), whereas this approach changed from April 2020. Consequently, care homes experienced a significant transition between the first and second waves such as facing significant regulatory changes, more interaction with healthcare personnel and regulators, and mandatory use of diagnostic technologies (Marshall et al., 2023). Our study reveals that care home staff had to navigate beyond the established guidelines to address complex needs of residents, staff, and families. Acknowledging that the legislation and the guidelines were the structures which shaped the activities of the care home staff, this paper explores the ways in which care home workers and managers drew on their experience and agency to provide the real and human-centred response to the government's enacted policies by adapting them to the practical and emotional realities of care home environments during the pandemic.

4. Methodology

This paper draws from a wider research project looking at COVID-19 outcomes in care homes in the South-West of England. The South-West of England has been facing distinct challenges to navigate in the social care sector. First, the South-West has seen a significant increase in its aging population compared to the UK average, with 35 % more people aged over 65 and 38 % more aged over (Hansford et al., 2023; the South-West Healthcare Market Insight, 2025). Second, the region is characterised by its rural landscape with an extensive coastline which

European Societies
https://doi.org/10.1162/EUSO.a.87

becomes a barrier when it comes to accessing to health and care services (Hodge et al., 2025). Third, the South-West of England, in recent years, has experienced only limited growth in care home supply in contrast to strong growth in many other regions such as London, East and West Midlands (Allan, 2021). The South-West Healthcare Market Insight report (2025) reveals that many care homes in the South-West could no longer afford rising property prices. Consequently, the region has experienced care home closures, resulted in the loss of a substantial number of beds. Unsurprisingly, there is a high demand for elderly care homes in the region.

Focusing on just one region within England - South-West – brings both advantages and disadvantages to our study. Considering the disadvantages, focusing on a single region limits our ability to engage with comparative insights across England. A related concern is that while our findings may resonate with experiences in other parts of the country, they may fail to capture regional differences. As for the advantages, it enabled us to give deeper insights into the experience of care homes and uncover the issues experienced within in a specific region. By focusing on the South-West of England, our study was able to better capture how care homes' responses to pandemic-related policies shaped care workers' and managers' experiences in that context. In doing so, our study contributes to the overall learning from the pandemic by giving particular attention to the experience in the South-West of England.

Following ethical approval from the HRA Social Care Research Ethics Committee (reference 22/IEC08/0019), we conducted a qualitative study to understand the experience of care home staff, including managers, in the South-West of England in managing COVID-19 during the pandemic. A semi-structured interview guide was developed, and interview questions sought to understand everyday experiences of care home staff and managers during the pandemic and identify challenges and solutions they encountered. Semi-structured interviews were chosen as a primary data collection method to explore the everyday practices and decision-making processes of care home workers. Recognising the discretionary nature of their work, particularly during pressing time of the COVID-19 pandemic, interviews proved especially appropriate. Data collection took place between November 2022 and September 2023. At the time the qualitative data was collected, care homes had already gone through a relatively extended period of the pandemic during which many important changes were introduced such as updates to isolation and visiting policies, the rollout of mandatory vaccination, revisions to testing guidance. Reflections on these changes during the interviews offered insights into how care homes had engaged with professional discretion in response to the needs of staff, residents, and their families.

Five care homes were recruited across different areas of the South-West of England. Fourteen semi-structured interviews were conducted with care home workers holding diverse roles and responsibilities. Four interviews were conducted with care home managers (three of which were joint interviews where managers were accompanied by a care home administrator/business manager/finance administrator). Recruitment followed two strategies, initially members of one of the local authorities in the region, who are collaborators on the wider research project, sent emails to care homes in their region and asked potential participants to contact the research team if they were interested in participating. To minimise the risks associated with this approach, we implemented several strategies, including offering flexible interview scheduling, holding pre-interview meetings to allow prospective participants to ask questions about the research, and clearly communicating the measures in place to ensure

European Societies
https://doi.org/10.1162/EUSO.a.87

confidentiality. However, many care homes did not respond positively to our outreach. Our conversations with care home managers who responded to emails but did not sign up to the research signals the time constraints faced by both managers and their staff. Following a low response rate, we contacted the regional Clinical Research Network (CRN) (now called Research Delivery Networks) who were establishing a network of care homes interested in research as part of the ENRICH project (NIHR, 2024). The CRN contacted care homes in the region and connected researchers with those willing to participate. To reduce potential gatekeeper bias, we encouraged CRN partners to circulate our call for participants as widely as possible within their networks rather than relying only on convenience or existing contacts. To support this, we used accessible language in our recruitment materials and asked CRN partners to share these documents transparently. All care homes and care home workers were provided with full study information prior to participation. Care workers were invited by care home managers and researchers clarified that participation was voluntary prior to consent. All interviews were audio-recorded and verbal consent was recorded prior to the commencement of the interview.

Interviews were transcribed verbatim and analysed with the support of NVivo 12 software. Each transcript was analysed by one researcher with a subsequent review conducted by another researcher to ensure congruence in coding and interpretation. A thematic analysis using a combination of both inductive and deductive approaches was employed. The deductive approach was employed to provide a structured framework consisting of themes for the coding process, whereas the inductive approach solely relied on participant experiences to guide and drive the entire analysis (Azungah, 2018).

5. Findings

The mobilization of professional discretion under crisis conditions by both care workers and managers centre around four key categories: strengthening infection control and prevention, promoting socialisation, enhanced communication and fostering intra- and inter-professional teamwork. These categories emerged aligned closely with the care homes' implicit priority agendas during the pandemic. First and foremost, protecting both residents and staff from being infected and the spread of the virus within care homes took the highest priority. This was followed by how to reduce feelings of loneliness among residents and increase indoor socialisation due to visitor restrictions. Then, how to maintain meaningful communication among care homes, residents, and their families and friends, despite isolation barriers and visitor restrictions, was an important agenda item as they had the responsibility for updating residents' families and friends about their situation. In the final category, care homes redirected their focus from residents and their families to their own staff by seeking alternative ways to foster collaboration within and between care homes during crisis times. Notably, a common element across these categories is *pioneering*, which we define as bringing innovative perspectives to established rules or practices, emerged as an additional way to managing down. To exemplify, although care homes were strictly required to follow isolation and visiting rules, some care homes included in this study, instead of just implementing such rules, introduced their own innovative practices which gave them the opportunity to minimise the potential side effects of top-down policies, such as arranging video calls, effectively using social media platforms to update resident's families and friends, and creating their own COVID-19 Update newsletter.

European Societies
https://doi.org/10.1162/EUSO.a.87

5.1.Strengthening infection control and prevention

The issue of how to ensure infection control and prevention was an agenda item for all care homes during the pandemic. Some studies report care home managers' struggle to secure key resources during the first wave of the pandemic (Marshall et al., 2023). Although securing access to key resources is vital, it only covers a single facet of the broader spectrum of infection control and prevention measures. Our study indicates that comprehensive infection control and prevention in care homes involves more than just resource access. In response, care homes implemented mostly 'strengthening' strategies to 'managing down' the risks, leveraging professional discretion to minimize the pandemic's impact on their infection control and prevention policies.

The UK government's delayed lockdown announcement and lack of priority for care homes in COVID-19 policymaking were noted as problematic by interviewees. The Government's 'downgrading approach' (Daly, 2020) to care homes in the first wave of the pandemic compelled some care homes to take proactive measures such as implementing early lockdowns, to protect both care home staff and residents before official directives:

> "We locked down before the government told everybody to lockdown. We had already made that decision. For safety you could see how things were going… We did that before we were even told to do that because you could see how things were going."
>
> Care Home 1, Manager

During the interview, the importance of exercising timely and effective professional discretion in uncertain times to ensure the well-being of both residents and staff was highlighted. Their early lockdown decision was based on their assessment of the evolving pandemic-related circumstances and the perceived threat to safety. This *pioneering* approach demonstrates how the management exercised professional discretion to enhance rules beyond official requirements, reflecting their commitment to *strengthening* safety measures in response to the evolving circumstances.

The same care home also introduced further infection control and prevention-related actions by establishing a bottom-up institutional policy practice of not accepting positive individuals being discharged from hospitals to the care home despite this being government policy for some time which could be read as a *countering* strategy:

> "On 31st of March 2020, there was a meeting with [the] local authority, [regional] hospital and the care homes in the area. The consultant advised that the [regional] hospital expected to run out of capacity and therefore it would be seeking to discharge COVID-19 positive patients to the care homes for them to have palliative care in the care homes. But our decision was that we weren't going to take any COVID-19 positive people. We would only accept if they had a COVID negative result."
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> Care Home 2, Manager

The care home's decision to refuse COVID-19 positive patients illustrates the care home management's challenge to prevailing guidance. By independently choosing to admit only those with a COVID-negative result, the manager prioritized resident safety over the directives from the hospital and local authority.

European Societies
https://doi.org/10.1162/EUSO.a.87

Another emerging theme is the importance of maintaining high hygiene levels in care homes to minimise the spread of coronavirus. All care home staff we interviewed showed a strong commitment to following rules and guidelines about infection control and prevention such as wearing full PPE, putting air filters in communal areas, restricting visitors, regular hand washing assessments, and increasing waste collection. As thorough implementation of all these measures requires effective teamwork, different supervision mechanisms were also introduced in care homes to ensure compliance with high hygiene standards and competency assessments:

> "It was compliance. We had loads of peers' compliance as well. So, our carer was set up to watch others while washing hand or do the competence assessment. We used our residents to do observations on the carer, so it was our activity. We have a special sheet, so the residents were watching carers washing their hands for 20 seconds and making sure that everything happened. So, we killed few birds [laughs]."
>
> Care Home 3, Care Coordinator

The implementation of a peer compliance system by involving residents in monitoring handwashing practices went beyond standard compliance measures. The use of residents as observers adds additional layers of accountability. Overall, this monitoring practice highlights the achievement of multiple objectives at once: prompting hygiene, ensuring competency, and involving residents in a meaningful activity. This action perfectly illustrates how existing rules are *strengthened* by *pioneering* a more rigorous system to ensure compliance.

Common to all interviews, there was reference to the spatial reorganisation of care homes, as an early response to the everyday challenges of the pandemic concerning infection control and prevention. To minimise the risk of the transmission of COVID-19 especially from care home staff to residents, a systematic approach was adopted, redesigning care home layouts (e.g., allocating separate rooms for testing, changing clothes, disinfecting before starting to work), during both pandemic waves:

> "We made a system. […] the home is having three floors: ground, first and second. There are two units on each side. And one of the units on the ground floor is having a high number of rooms with a patio door to the garden. And at that time, I had the second floor empty, so we spoke with the families, there is an emergency, and we need to change the rooms. So, we moved all the people on the ground floor, to the second floor. And we've done the ground floor as a welcome unit. So, any discharge from hospital will come from the garden directly into the room, not in any other areas of the home for two weeks isolation. And then with tests and everything will be moved in any other areas of the home. Then the other unit that was empty on the second floor we've done it for staff because we do have team members with family members who needed to isolate, or they're not allowed to go out in that time for medical reasons. […]"
>
> Care Home 3, Manager

The interview notes a common point among care homes: lacking full capacity at the pandemic's onset. Lacking capacity prompted them to adapt to the emerging situation through spatial reorganisation, indicating the care home management's efforts to *strengthen* existing safety measures in response to the pandemic. Dividing a care home into units to accommodate isolation requirements for both residents and staff members showed care homes' *pioneering*

European Societies
https://doi.org/10.1162/EUSO.a.87

skills to introduce adaptable responses to the challenges of the pandemic.

The development of COVID-19 vaccines was one of the turning points of the pandemic. However, many care homes around the world experienced vaccine resistance and/or hesitancy (Gordon et al., 2022). As a response, mandatory vaccination for care home workers was introduced in many countries, including the UK, with the aim of increasing vaccination rates among staff. Unsurprisingly, participants of this study also reported vaccine resistance and/or hesitancy as one of the barriers to infection control and prevention. Care homes whose employees refused to be vaccinated had to terminate employment of their employees as mandated by the government policy (DHSC, 2021). Instead of letting their employees leave, some care homes launched their own vaccination campaign to address vaccine resistance and/or hesitancy:

> "We encourage them to have flu and COVID [vaccinations] if they will, but we did try to persuade them, I mean the management, not me but the managers did offer a monetary sort of bonus if you did go and have the COVID vaccine. So, some people did, and you'd get a bonus if you sent your vaccination certificate in, that was one incentive for some people. Some people were just going to have it anyway. But some people don't want it and still don't, you know, we didn't have anyone who was anti vaccine, but they just didn't want another one when they'd had a few, they thought they'd had enough."
>
> Care Home 2, Assistant Manager

This interview reveals a multi-faceted approach to vaccination encouragement involving persuasion and incentives (in the form of a monetary bonus) and acknowledges that individual decisions can be influenced by various factors. While there was a general effort to persuade care home staff, the management went a step further by offering a monetary bonus as an incentive for those who chose to be vaccinated which goes beyond simply encouraging vaccination. The implementation of this incentive demonstrates a proactive-*pioneering* stance by the care home management to *strengthen* the adherence to guidelines among.

The highlighted policy practices, concerning infection control and prevention, illustrate that care homes could be capable and flexible enough to initiate their own strategic and adaptable responses to the challenges caused by uncertain situations (i.e., pandemic) and ambiguous policies (i.e., the government's late response and fragmented policy between national and local levels) by developing their own organisational approach and utilising their own resources. In navigating the complexities of infection and prevention control during the pandemic, care homes exemplify the role of experts in influencing professional discretion through demonstrating their ability to creatively interpret national guidance, adapting to evolving circumstances, and implementing effective strategies tailored to their specific contexts and resources.

5.2. Promoting socialisation

Existing studies reveal that the pandemic fuelled feelings of loneliness among residents due to social contact restrictions, isolation and barriers to person-centred care (Ho et al., 2022). In our interviews, a lack of socialisation is reported as an additional everyday challenge that care homes encountered during the pandemic. To mitigate the pandemic's negative impact on

European Societies
https://doi.org/10.1162/EUSO.a.87

residents' mental well-being, care homes introduced their own socialisation-related policy practices. Our findings identified two different but interrelated response mechanisms. The first one is developing *an innovative meeting system*. Owing to isolation rules and visiting restrictions, residents were unable to see their family and friends as often as they used to. In addition to using technology for virtual calls between residents and family and friends, one interviewed care home developed a systematic approach for safe, organised, and efficient visits:

> "[…] My second unit on the ground floor, the lounge was designed as a visitor's room. So, basically the manager ordered a window, it was a huge one, she paid thousands of pounds for that. It was placed in the middle of the lounge. And on one side where it was accessed from the garden, there were two chairs and a table for the families to come and see their loved ones, and to guard their health we used to bring the residents from inside of the building with microphones, and they could come and see each other, which was really good for the residents and the impact on them was huge."
>
> Care Home 3, Deputy Manager

The meeting system mentioned by the interviewee functions as an electronic booking system for family visits. While not a standard requirement, it was implemented as an additional measure to facilitate safe visits between residents and their families. This collaborative effort between care homes and visitors *strengthens* established guidelines on care home visiting, improving standard practices to support resident interactions and promote mental well-being.

Another response mechanism to boost socialisation was to *increase and diversify activities* within care home settings. Due to isolation and visiting restrictions, residents were unable to engage with outdoor activities or to see their loved ones as frequently as they used to. To counter this challenge, care homes emphasised a need for boosting indoor socialisation. Increasing and diversifying indoor activities was considered an essential solution for keeping residents engaged and occupied. Thus, some care homes adopted a community-oriented response to the socialisation-related challenges:

> "We were doing something amazing as well, because we have lots of contacts with external groups, and whatever activities we were doing during COVID, we were producing something called [anonymised]. So, the activities that we were producing or performing in the care home, I was writing down instructions, and we were sending this via email to different dementia groups and the carers in [anonymised], so they could participate in this as well. Because they were staying at home, bored, or not knowing what to do with themselves, so we were offering them this. We did a time capsule, a COVID time capsule. So, in a little capsule we put things about what was happening in COVID, like a mask, an explanation for future generations about what was happening."
>
> Care Home 3, Care Coordinator

This initiative indicates that the care home not only adopted activities for residents but also reached out to external groups which fostered a sense of connection and shared experiences during uncertain times. The care home went beyond its original realm of responsibility by sharing its own resources and activities with individuals who were staying at home, potentially experiencing boredom and uncertainty, benefitting larger audience. Hence, this initiative captures the long-term impact of COVID-19 since the care home management prioritised engagement and connection with external dementia groups and their caregivers during the

European Societies
https://doi.org/10.1162/EUSO.a.87

pandemic. This approach not only safeguards these important experiences for posterity but also illustrates expertise through *pioneering* care into meaningful action. All in all, innovative socialisation policies initiated by care homes remind us of the pivotal role of professional discretion in their capability to adapt policies to meet the unique needs of residents.

5.3. Enhanced communication

During the pandemic, care homes encountered the challenge of sustaining meaningful communication among care homes, residents, and their families and friends due to imposed visiting restrictions. All interviewed care homes emphasized the practicality and effectiveness of video calls in maintaining contact between residents and their families and friends during the pandemic:

> "Well, we started doing video calls, so that residents could still have contact with their families via technology. It was quite new to some of us as well because I hadn't really used it before and it's quite a challenge for some of the residents because they didn't quite understand why their loved ones were on the telly. But it gave them another way of communicating […]"
>
> Care Home 1, Manager

The care home prioritised maintaining social contact by introducing video calls, suggesting a proactive response to communication-related challenges during the pandemic. This technology-enabled communication was crucial for maintaining emotional connections and reducing feelings of isolation and loneliness. Despite the potential unfamiliarity of care home staff with technology, insistence on the use of new technological tools accentuates care home's adaptability and ability to *translate* their knowledge into innovative solutions.

In care homes, communication involves three parties: residents, their families and friends, and the care home. Therefore, care homes mobilised themselves to use a proactive approach to foster effective communication between themselves, residents, and their families and friends:

> "In terms of communication, I was responsible for the weekly updates for the families. We had a little newspaper called [anonymised], and we sent it with everything that was going on with COVID, whatever the local authorities were sending us, the new government updates, later-on taking bookings for visiting, that was me. So, every Friday - we've only stopped it recently - the families were still saying, 'Oh, I haven't received my Friday update,' but it was an amazing way to keep families, reassured, and making sure that they know what we are doing. So, we always had that. If the changes were implemented for the visiting, there was a reason behind it, it wasn't us, it was the government it was those procedures."
>
> Care Home 3, Care Coordinator

Issuing a weekly newsletter emerged as a *pioneering* response to maintain open lines of communication during a challenging time. The comprehensive weekly newsletter format signals a transparent approach to keeping residents' family and friends informed about the evolving situation. Care homes typically informed families and friends about residents' well-being and updating them about everchanging procedures such as visiting. Yet, the care home

European Societies
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expanded its responsibility by embracing a more inclusive strategy including information on local directives and government guidelines related to pandemic. This reflected a direct transmission of information as it was formally communicated, clearly aligning with *passing*.

Some care homes implemented a slightly different strategy to update residents' families and friends. Our data reveals many care homes use closed *Facebook* groups to share updates on residents' situations. The Facebook group functions as a digital information-sharing service that serves as a source of updates for residents' families and friends:

> "[…] Yes, so what we did with that group as well, so it was an information giving service but also, we put pictures of all the residents on there every day. So, we were showing them what the residents were doing, showing all the activities, trying to sort of put happy pictures on there, you know […]"
>
> Care home 4, Care Coordinator

Certainly, opening a closed Facebook group played a crucial role in constantly keeping families informed about the well-being and activities of their loved ones. Hence, the conversation above highlights the success of an information-sharing service through a social media platform that goes beyond providing updates, such as incorporating daily pictures of residents to create a positive and reassuring connection with their loved ones. That embracing technological tools like video calls or social media groups/pages to facilitate communication between residents and their families and friends indicates the potential for care homes engage with adaptable solutions to social interaction barriers and support and *strengthen and pioneer* the standard information-sharing practices.

5.4. Fostering intra- and inter-professional teamwork

During the initial wave of the pandemic, care home managers tended toward a command-and-control approach due to resource shortages, high mortality, and limited guidance. However, a more flattened hierarchy subsequently emerged, as care home managers adopted a reflexive and strategic stance in response to constantly changing and ambiguous demands imposed on them (Marshall et al., 2023). Interviews confirm managerial challenges care homes faced during the pandemic, such as staff shortages due to many factors (e.g., Brexit, pandemic, low pay); lack of staff capacity (i.e., not all employees are skilled with the delivery of infection prevention and control); limited guidance feeding into heightened responsibility for effective decision-making; and fragmented policy between national and local levels, which resulted in confusion regarding what level of policy guidance should be followed. Our data points to two different initiatives adopted by care home managers in response to managerial challenges. The first one is assigning multiple roles to care home workers. Many care workers, during the pandemic, suffered from physical exhaustion that resulted in anxiety and stress (Beattie et al., 2023). This is unsurprising given that their working conditions worsened compared to pre-pandemic times. However, some care homes attempted to turn this negative experience into an advantage by adjusting their care delivery model:

> "[…] So, we're now looking at what people can do outside of their role. So, for example, we have carers that we now know that can cook in the kitchen, so they do shifts in the kitchen in part of X's team. There's a gentleman that's on reception but he also runs the kitchen if he wants to or when he's required to because he's trained to do that. So since the pandemic we've become more diverse in the way we do things, so we

European Societies
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> don't just have carers performing care and activity assistants doing activities; everybody literally does everything or anything and that's what's changed, not the delivery of care. The standard of care is still the same but who delivers certain parts of care has changed a little bit."
>
> Care Home 4, Manager

While the standard of care is presented as consistent, the care delivery model, particularly with the introduction of well-being assistants, is *translated* into the utilisation of staff in multiple roles. The well-being assistants, many of whom have previous experiences as carers, bring additional skills to their roles. This reflects a *pioneering* approach to personnel selection, tapping into the diverse skill sets of carers who have experience beyond their current responsibilities. This adaptation highlights a prioritisation of flexibility and resourcefulness in response to the evolving needs.

Interviews also highlighted the importance of inter-care home communication within neighbourhoods to ensure comprehensive policy implementation. This information exchange serves as a response mechanism for navigating managerial uncertainties during the pandemic:

> "[…] We had [anonymised] Care Home Collaborative that was set up just to kind of make sure that we were all especially managers as well because we were sort of sat at the top and we were responsible for protecting everybody and still kind of getting all the pressure and not really knowing what was going on and not really knowing what we should be doing and that was difficult. So, as managers, we kind of created our own little safety network of sharing information and support."
>
> Care Home 5, Manager

The interviewee stresses the significance of inter-care home communication during a challenging period. The collaborative effort served as a platform for sharing information, navigating uncertainty, and offering mutual support, highlighting the value of collective efforts in addressing complex issues within care homes. This approach can be seen as *buffering*, designed to shield the management team from the full impact of external pressures and uncertainties. By fostering an environment of internal support, this initiative helped manage challenges without unduly transferring all the pressures or uncertainties to the broader staff.

Insights from care home workers highlight the resilience and adaptability of care homes during the pandemic. Despite managerial challenges and uncertainties, the adoption of *pioneering* strategies such as a new working model or the establishment of collaborative networks reflects proactive responses to residents' evolving needs, on the one hand. On the other hand, it illustrates the importance of mutual support among care home managers in navigating the complexities and pressures associated with their roles. These efforts collectively demonstrate care homes' commitments to resident well-being during unprecedented circumstances brought about by the pandemic.

6. Conclusion

Summary of findings

Our research questions asked what the perspectives of care home staff, including managers, were regarding COVID-19 policies and procedures and what was their experience of working in care homes during the pandemic. We also sought to find how professional manners and

European Societies
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organisational practices were mobilised by both care home workers and managers during the pandemic to mitigate the impact of the pandemic on daily life within their settings.

Our findings indicate that care home managers and deputy managers within our sample were highly aware of Government policies and procedures around the pandemic. Workers actively evaluated policy and guidance. There was strong support for certain risk reduction measures such as the use of PPE equipment, increased hand washing and visitor restrictions. Nonetheless, these participants were critical of other policies, most notably the discharge of those with symptoms of COVID-19 to care home, leading them to counter and resist such policies. In this way, care workers and managers used their professional discretion to strengthen infection control and prevention. Whilst the focus of policy and guidance was on facilitating discharge from the NHS and risk reduction, participants identified non-clinical risks to their residents, namely isolation and loneliness. Policies and procedures were subsequently augmented to promote socialisation, and to increase and diversify activities within care homes. Further measures such as videocalls and newsletters were used to enhance communication. Additionally, care homes actively strove for mutual support to tackle with managerial challenges within and between care homes.

Limitations

The research has limitations. First, the geographical scope is limited as we focused only on the South-West of England which may have led to a limited understanding of the various experiences of care home staff across a wide range of care homes. A comparative analysis across different UK regions would provide broader insights into whether other care homes across England experience everyday challenges of the pandemic in similar ways or not. Next, recruitment challenges affected our ability to purposively sample care homes participating in this study. Lastly, care homes that participated in this study experienced a small percentage of deaths. Therefore, there was a strong emphasis in the interviews on "we somehow managed to successfully overcome pandemic-related challenges of working". Further research can unpack experiences of care homes that experienced excess mortality compared to those that did not and accordingly identify factors leading to the adoption of different responses to the challenges of the pandemic among care homes. Relatedly, it is important to note that our findings are situated within South-West England's care homes, offering contextualised understanding of their experiences during the pandemic; thus, we acknowledge limitations considering the generalisability of our findings. Yet, our analytical categories regarding how carers exercised discretion, by developing innovative practices and/or responses to the everyday challenges of the COVID-19 pandemic, is operated in care home settings such as reinforcing infection control and prevention, promoting socialisation, enhancing communication, and fostering collaboration may resonate with similar country contexts, sharing similar welfare structures and policy frameworks.

Theoretical contribution

To our knowledge, this is one of few studies, which explores how care home staff employed street-level bureaucracy during the COVID-19 pandemic. This study makes three main contributions to the existing literature. First, our findings contribute to the theoretical development of the literature on 'street-level bureaucracy' by drawing attention to the crucial role of not only care home staff, but also managers in mediating and interpreting policies. Acknowledging the reciprocal relationship between the frontline and managerial levels (Evans,

European Societies
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2010), care homes, when necessary, acted as intermediate actors in the absence of policy guidance (the period till mid-April 2020) or the mediation of the government's fragmented policy responses (the period referring to mid-April and onwards) by mobilising their professional discretion. Second, there is an extant literature on street-level bureaucracy in 'normal times' but there is a notable lack of research on such dynamics during atypical times, such as the pandemic. By focusing on care homes, we demonstrate their capability to embrace not only strategic approaches (e.g., strengthening, buffering, countering, translating, passing) (Hupe and Keiser, 2019), but also innovative responses (e.g., pioneering) to cope with uncertainty arising from the pandemic. Therefore, *pioneering*, which emerges as another way of 'managing down', advances our understanding of how professional discretion provides room for acting creatively and navigating between policy and practice under crisis conditions. Third, existing studies mostly portray a negative image of the situation of care homes during the pandemic (Daley et al., 2022; Hanna et al., 2022: Schultze et al., 2022; Titley et al., 2023), but this study points out care homes' agency and ability to introduce their own coping strategies when dealing with various tensions in their day-to-day work during the pandemic. This not only emphasises their adaptability in the face of adversity but also highlights their capacity and resourcefulness to address and navigate the multifaceted tensions inherent in their daily work.

Policy implications

Commentary has shown that the needs of care homes were largely overlooked during the first wave of COVID-19 and did not begin to be addressed until mid-April 2020 (Daley et al, 2022; Daly, 2020). Our paper identifies the need for care homes residents and staff to be identified by policymakers from the outset, rather than policies viewing care home provision as a mechanism to reduce pressures on the health service. It also identifies the need for policymakers to engage more effectively with care home workers and managers to identify the needs of care homes. Finally, our paper concurs with findings elsewhere, which identify a need for policymakers to raise the status of care workers and managers (Crozier and Atkinson, 2024). As our findings indicate, such workers are concerned to actively promote the welfare of care home residents and can adapt existing policies and to provide innovative solutions to practice problems. These skills need to be recognised and celebrated.

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