



**Themes and Learning from ADASS Members on the Local
Response to COVID-19 in Spring and Early Summer 2020**

October 2020

Foreword

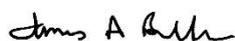
In early 2020 when the coronavirus pandemic hit England, adult social care colleagues were immediately caught up in the work to ensure that there was capacity in our NHS hospitals to treat people who needed inpatient care. We had no knowledge in early March of how many people with care and support needs would be affected by this new virus, or what the impact would be on our services. What we did know, however, from previous work undertaken on pandemic flu planning, was that the “tail” of the first wave was likely to last for a much longer period in adult social care than in the acute hospitals. The immediate crisis faced by adult social care in late March and early April would only be the beginning of a sustained incident to which ADASS members would have to respond.

The Government recognised that local authorities and care providers would face rapidly growing pressures as care workers had to self-isolate or were unable to work for other reasons at the same time as more people would need support. In response, the government put in place a range of measures as part of the Coronavirus Act 2020, to help the care system manage these pressures and balance them with the requirement to protect and safeguarding people within the Care Act 2014. Whilst local authorities were expected to do everything they could to continue meeting their existing duties under the Care Act, in the event that they were unable to do so, the measures, referred to as “Care Act easements” were intended to enable local authorities to streamline their Care Act assessment arrangements and prioritise care so that the most urgent and acute needs could be met. The Coronavirus Act amended the Care Act and effectively enabled local authorities to prioritise more effectively where necessary than would be possible under the Care Act 2014 prior to its amendment. The easements were intended to be time-limited and were to be used as narrowly as possible.

When ADASS was invited by DHSC to be involved in a working group to develop the guidance to support the use of the Care Act easements, we, along with others in the sector, including TLAP members, agreed. This work was overseen by the **National Adult Social Care (Covid-19) Group (NACG)**, which we both attended and James co-chaired.

As the Coronavirus Act 2020 was given Royal Assent and the Care Act easements guidance was published, the NACG turned its attention to how best to understand the impact of the easements. TLAP agreed to convene the TLAP Insight Group and to gather insight from a wide range of partners, particularly focussed on the impact on people with lived experience. ADASS decided to seek the reflections of Directors of Adult Social Services, to feed into the wider understanding of the impact. Following a conversation with colleagues in the West Midlands branch, James proposed that this work would provide a richer picture if it included both ADASS members who had not operated the Care Act easements as well as those who had. The work for this report evolved from simply considering the impact of the easements to considering more widely the impact of COVID-19. TLAP representatives were able to join meetings with six of the contributing local authorities and early emerging messages were fed into the TLAP Insight Group during July 2020.

We would like to extend our great thanks to all our contributors from the thirteen local authorities, including Directors, Assistant Directors and Principal Social Workers, for giving their precious time to contribute to this report at a time of great pressure. We also wish to express our appreciation for the openness and honesty shown by colleagues in sharing their experience and reflections of leading their organisations at a time of crisis and flux. The report contains valuable learning and insights, which we commend to colleagues, as we respond to a second wave of the pandemic and continue working across the sector and with people and families to forge a stronger and better future for social care.



James Bullion
ADASS President



Clenton Farquharson, MBE
Chair of Think Local Act Personal

The Association of Directors of Adults Social Services is a charity. Our objectives include:

- Furthering comprehensive, equitable, social policies and plans which reflect and shape the economic and social environment of the time
- Furthering the interests of those who need social care services regardless of their backgrounds and status and
- Promoting high standards of social care services

Our members are current and former directors of adult care or social services and their senior staff.

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Introduction

As part of the response to the Coronavirus pandemic, ADASS was invited by the Department of Health and Social Care (DHSC) to contribute to the work on the [national guidance on the Care Act Easements](#) along with other partners. The national guidance was kept under review and during the period when easements were being operated by some councils, it was agreed that it was important to understand the impact of easements on people with care and support needs. Think Local Act Personal (TLAP) agreed to coordinate an insight group to draw together the experience of a wide range of partners. As part of this work, ADASS agreed to gather the reflections of some of its members to enable learning from a local perspective for future waves of the pandemic. Whilst this work was initially planned to focus on the impact of easements, it was soon widened out to seek reflections in both easements and non-easements local authority areas on the impact of COVID-19.

It is worth noting that the adult social care sector was not the only sector that was having to consider changes to how it delivered its services. Whilst it was considering whether it was necessary to apply Care Act easements, NHS Trusts were considering cancelling elective surgery, school buildings were closed to most pupils, developing online and home learning resources, and dentists and opticians stopped providing services.

At the same time as considering how to get care and support to those who most needed it in the crisis, local authority Adult Social Care departments were also responding constructively to additional issues, such trying to support local service providers to deliver care and support when the supply of personal protective equipment (PPE) failed, and working with council, LRF and voluntary sector partners and community groups, to provide practical support to people who were described as clinically vulnerable or clinically extremely vulnerable people who were isolating, or rough sleepers in finding a roof to go over their heads. In many cases, council services stepped up when national initiatives failed.

Contributors to this report have highlighted many examples of positive work in their communities. They also were dealing with other issues, such as a drop in referrals in the early months of the pandemic, including safeguarding referrals, followed by an increase as lives began to open back up. It is anticipated that there will still be much unknown and unmet need that is likely to emerge over time, whether that is carer breakdown, safeguarding issues, DoLS challenges, people ending up in crime for want of support or employment. The summer months have given a period of respite for some as doors re-opened, people were able to go out again and many family members have been able to visit loved ones again.

A second wave is anticipated, however, and it is important to reflect on, and learn from, our experience of the first wave. This report is offered as a contribution to that learning.

Method

ADASS invited Directors of Adult Social Services (DASSs) to take part, both those who had operated the easements and those who had not. Thirteen DASSs contributed to this report. Of these, 8 of their councils used the Care Act easements during the Spring of 2020 and 5 Councils did not. Initial meetings were held by telephone or video call. 6 of the initial meetings were held jointly with representatives from TLAP, who were also undertaking work on the impact of the responses to COVID-19 for people with lived experience.

The initial meetings were to gain an understanding of the context in each area, how they had responded to COVID-19 including whether they had used easements, and what their reflections were on how it had worked.

Subsequently, further work was undertaken on more detailed questions. Some councils provided written accounts of their experiences, others took part in interviews and agreed the final text. In some councils, views were also contributed by principle social workers and assistant directors in addition to the reflections of the DASS. Some provided reports and examples of what they had done in their local authority area.

The findings were then combined to identify key themes, both for those who operated the easements and those who did not, and learning for sharing with colleagues in local authorities and learning for sharing with Government. For more information about the TLAP Insight Group work, see "[A Telling Experience: Understanding the Impact of COVID-19 on People who Access Care and Support – A Rapid Evidence Review with Recommendations](#)", recently published by TLAP.

Councils that have contributed to this report

Councils that operated under Easements during the period

- Derbyshire County Council
- Warwickshire County Council
- Staffordshire County Council
- Birmingham City Council
- Sunderland City Council
- Solihull Metropolitan Borough Council
- Coventry City Council
- Middlesbrough

Councils that did not operate under Easements during the period

- Gloucestershire
- Nottinghamshire
- West Sussex
- Hull
- Stoke-on-Trent

Themes and Learning

Themes – Easements Areas

1. No council brought in all of the possible easements included in the guidance.
2. Some councils only utilised a small number of the easements.
3. Some councils prepared to use certain easements and then they found they did not need to all the easements they had planned to utilise.
4. Most councils reduced the length of the required recording of assessments and care plans, to enable less time to be required for each. Some designed new cut down templates, others used more free text approaches.
5. At the beginning of the pandemic (March/early April), there was a rush to discharge people from hospital to free up acute hospital and intensive care beds that would be needed to treat people who had COVID-19. This had a major impact on the rest of the health and social care system, across the country (not just in easements areas), as everything was focussed on protecting the NHS, which proved to be the detriment of those in other services.
6. Most councils moved to virtual assessments, where possible (video and telephone assessments), and postponed scheduled reviews to a later date, but all kept unscheduled reviews, which are undertaken with people when their needs change between reviews.
7. Most councils redeployed staff from reviewing teams and, in some cases, occupational therapy teams, to where the pressure or need was greater. This included:
 - hospital discharge/community assessment teams, where it was deemed essential to prioritise the needs assessment for people who were not yet receiving care and support services.
 - home care services, either council-run services or as part of mutual aid for the independent sector workforce.
8. Some councils recruited additional staff into home care services (both in-house and independent sector).
9. Some areas were really impacted by black, Asian and minority ethnic community (BAME) issues, both in the workforce and among people with care and support needs.
10. Referrals initially went down across the country (not just in easements areas), including safeguarding concerns and DoLS referrals.
11. Some councils continued to do financial assessments, but not charge.
12. Some, though not all, decided they would charge retrospectively, once financial assessments could be re-introduced.

13. The Care Act Easements legislation allowed for Councils to suspend the use of national eligibility criteria for adult social care services. Instead of determining whether a person was eligible under these criteria and providing care services to people who were, the easements permitted councils to stop determining eligibility, and instead to provide care and support services to people whose human rights would be breached without those services. In the event, no council moved from Care Act eligibility to a human rights threshold. Some adult social care directorates, especially in unitary council areas, were responsible for coordinating their council's support for "clinically vulnerable" and "clinically extremely vulnerable" people and for rough sleepers and the early release of prisoners. This meant that for those areas, the adult social care offer was effectively widened rather than narrowed, as support services were provided to people who would not have been eligible for care and support services under the Care Act (2014).
14. Most councils risk assessed/RAG-rated the needs of all people who were in receipt of home care packages, in case home care services had to be reduced/re-prioritised.
15. Many councils sought alternative ways to meet assessed needs while day centres were closed, due to social distancing requirements.
16. The initial focus in all areas was on protecting the NHS and emptying the hospital beds.
17. Care homes generally wanted to "do the right thing". Some care homes were asked by councils as well as by the NHS:
 - to take people who had not been tested
 - to take people who were COVID positive.
18. Some local authorities were in real crisis very soon after the guidance was published and had to declare easements whilst still completing preparation.
19. Some councils recognised they could have spoken to disability groups earlier, as well as to individuals who were in receipt of care and support services. It was recognised that this could have helped with getting consistent messages out in the local authority area sooner. In many cases this was progressed as soon as the omission was recognised.
20. Some were acutely aware of frightening or worrying people, both people in receipt of care and support services and their families and carers.

Themes – Non-Easements areas

21. Many of the approaches used by councils that did not operate the easements were similar to those used by councils that did.

22. Councils moved to using remote (telephone, video) assessment and review approaches, wherever possible. Where it wasn't possible to speak to the person with care and support needs using these means, assessors spoke to family, friends and staff to gain the information.
23. Like in easements areas, reduced assessment paperwork was used.
24. There was more time available to spend on the preparation of processes to inform decision-making on whether to move to operating under easements.
25. Councils introduced regular review check-points, to aid decision-making about whether to move into easements.
26. Non-easements councils who contributed to this report had lower infection rates and were therefore operating in less of a crisis during the early weeks of the pandemic. This enabled them to have more time available to achieve more clarity in describing the triggers that would require easements to be declared and therefore achieve more clarity.
27. Most of these councils undertook risk assessment/RAG-rating of people who receive home care services in readiness, in case home care services had to be reduced or re-prioritised due to lack of staff. In the event of a council needing to suspend its use of the Care Act eligibility criteria, this risk assessment would have supported councils to consider, for each person, whether not receiving those services would have breached the person's human rights.
28. Most of these councils found alternative ways to meet assessed needs while day centres were closed. Some councils were able to avoid the total closure of day services.
29. There was more time for liaison with disability organisations, local Healthwatch and individuals, to discuss the local responses to the pandemic.
30. The councils who did not operate the easements were not faced with an immediate crisis, and were therefore able to use more time to consider the local situation, and to take a slightly more measured approach. They had the comfort of being able to prepare first and then, if and when easements were needed, they had agreed approaches to move into operating them.

Learning for Sharing

31. If possible, prepare first. Agree the monitoring, triggers and governance systems, risk assessment approaches for individuals with care and support needs and then switch on easements at the last possible moment "when the house is on fire".
32. Talk to local stakeholders – council colleagues, members, H&WB Board, local disability organisations, NHS colleagues, Healthwatch, front-line staff – early – get buy in and consistency in messaging. Share the messaging, reasons, risks of not taking action and the communications. Use as many channels as possible to get the message out (local press, TV, charity newsletters and bulletins).

33. Explain how the crisis is being experienced locally by Adult Social Care services in both the council and the private and voluntary sector and ensure that people, partners and public, understand the key distinct role of adult social care compared with the health service.
34. Speak directly to individuals who may be affected by changes.
35. Ensure risk assessment/rating the risk (high, medium, low) for both individuals and identifiable groups and consider mitigations should actions be required.
36. Review the position about how best to “protect the NHS” – This must not be at the expense of older and disabled people who need social care or mean that such individuals and groups are further disadvantaged. Remain strong about testing and not introducing COVID-positive people into collective settings.
37. Where the impact of COVID-19 on specific groups are already understood from published findings, such as the Public Health England Report *Beyond the data: Understanding the impact of COVID-19 on BAME groups*, seek out and support those people where COVID-19 has exposed inequalities most.
38. If possible, offer regular calls and offers of help to people with care and support needs, particularly for direct payments recipients, who are not included through or supported by provider representative associations.
39. Maintain an “open door” through as many methods as possible – offer a council helpline for people to contact if they are in need of help.
40. With the coming of some easing of lockdown, note that the pandemic wave has a “longer tail” in adult social care than in other sectors. When other sectors start talking of recovery, this is not anywhere near the end for adult social care. Colleagues need to take advantage of lulls – time to catch breath, take breaks, holidays and prepare for the next wave, but the work of adult social care continues to be to respond to a “sustained incident”.
41. There was initially a decline in demand (particularly in the demand for care and support services in the home) as many family members were furloughed or working from home and able to provide care and support. This capacity, both the practical and physical, but also emotional, has limits. There is a real risk of later burnout among some family members, and a subsequent increase in demand.
42. The need for respite for both paid and unpaid carers needs ongoing review and consideration. When regular community activities are all halted and people cannot simply go out and spend time with others for a few hours or go stay somewhere else for a few days, there are fewer familiar options and more creativity may be needed for those who find they cannot continue without a break.
43. There is a need to factor shared lives carers into the needs for breaks. Many supported people for a higher proportion of the time than usual during the emergency period. The requirements not to mix with other households meant they tried to cope without their scheduled breaks.

44. During a second or subsequent wave, energy levels may not be as great, and respite services may be even more important. They may also be needed during, rather than after, the wave.
45. Home care providers experienced real pressures during the pandemic – both concerns about the wellbeing of their own workforce, and also business concerns as their services were turned away by frightened individuals and families.
46. Whilst pressures on care homes have come to the attention of government and the public, following the number of deaths due to COVID-19, other services also need to be supported to continue and build capacity again where needed and where possible. If fewer people want, or are able, to move into residential or nursing care, then the building up of care at home and housing-based models is extremely important.
47. Adult Social Care commissioners have a crucial role, continuing to work with providers in their areas, considering their needs during the worst points of the pandemic in their area and also planning for afterwards. Commissioners also have responsibilities for planning for the risk of provider failure, managing closures and re-provision to different models of care.
48. Depending on local organisational structures, principal social workers (PSWs) in some councils work more routinely with commissioning colleagues than in others. Given the centrality of the PSW role in the Care Act Easements guidance in decision making around easements, it is important to ensure that up-to-date, local commissioning intelligence is also fed into the discussions.
49. In terms of the experience for people with care and support needs, remote assessments worked well for some. Some handled telephone and video calls better than had been anticipated. Whilst prior to the pandemic, it was assumed that face-to-face assessments were best, there were some instances where the required alternatives worked even better. This was not universal and for some, such methods were a struggle. When it is not essential to use remote methods, a case by case basis should be used to judge what would work best for each person.
50. From a practice and workforce point of view, it was noted that remote working with less travel can be more productive. In some areas waiting lists reduced, and this could be attributed to a combination of demand levels reducing at the beginning of the pandemic as well as more productive use of time.
51. More strength-based responses were developed in the absence of alternatives. Family solutions often worked well. Due to the lack of access, professionals found they had to trust family members or colleagues to provide information to prevent the need for more face-to-face contact (an example was provided of a social worker undertaking measurements for an occupational therapist). This enabled an efficient use of time, and the experience and outcomes could provide useful evidence to inform practice, going forward.

52. There was a great deal of concern in some areas about a drop experienced in the number of safeguarding concerns being raised. This was generally attributed to lockdown rather than easements. In particular there were concerns in relation to “closed institutions” where nobody was visiting, so nobody external had “eyes on” individuals or their environment. Some care homes allowed visits, others didn’t. Since national visiting guidance has been published, and councils have had access to more regular and more local data, DASSs, PSWs and commissioners have been able to work more closely with their public health colleagues and to develop responses that are more sensitive to very local data on case numbers, enabling support to care homes with decisions on visiting restrictions.

Learning for exploring with Government

53. Early in the crisis period, the Care Act Easements rapidly became politicised and generated an intense level of scrutiny (and some curiosity) that was detrimental to the work of those councils who implemented the easements and created unhelpful publicity, potential reputational risk and concern amongst local people. Councils that decided to use the easements were heavily criticised by the rights organisation, Liberty, and some legal organisations.

54. It is essential for the public to have clarity on purpose of the easements. They were introduced to enable the best use of scarce resources in a crisis. Pandemic flu guidance had indicated that reasonable worst case would be that 20% of staff and 20% of family carers could be out of action. The Government has a part to play in communicating this and that using the easements at the proper time, following the required due process may be required and that is why the framework has been provided. Whilst the use of easements should be a last resort, and warrants careful decision-making, the purpose is to get care and support to those who most need it at a time when the workforce is under pressure.

55. If the purpose of the national guidance is to enable the swiftest and safest prioritisation when there is genuinely not enough capacity to meet demand, the process needs to be simpler, but more fully recognise the fears people will have about ‘losing rights’ and about services sometimes not being sufficient to meet social and psychological as well as physical need. Some found the national guidance unclear and felt that this made it open to interpretation, resulting in it being easy to challenge a council’s approach (see paragraph 59 for examples). It is intended to be a process by which to put flexibilities in place quickly, but it sets the bar too high in terms of the amount of ‘groundwork’ expected and anticipated. If a council is experiencing crisis, with fewer resources available, it takes even more time than normal to undertake this sort of work.

56. Utilising the Care Act easements was not just about the extraordinarily difficult decision to reduce support for some people. It was also about helping maintain staff safety, protect staff and demonstrate support to staff. Social care staff were already recognised nationally as being under pressure pre-COVID-19 and as

commissioner and employer, it was appropriate for Councils to consider the limit of reasonable expectations with regards to staff working arrangements, recognising that many chose to go 'the extra mile and beyond' during the crisis period. It was difficult to develop communications that articulated this balance in a way that would be constructively interpreted by all stakeholders, and it would be helpful if national guidance more strongly acknowledged this difficult balance and the extraordinary commitment, compassion and courage shown by everyone – care staff, social workers, commissioners, back office staff and managers.

57. Adult Social Care provides a crucial role – the sector employs many people – more than the NHS. Many of the people supported by adult social care receive care and support services in the community that are unrelated to discharge from hospital, or the immediate prevention of an admission to hospital. It is essential to support adult social care in its own right, and not only to protect the NHS from being overwhelmed.

58. The PSW played a vital role in determining whether it was appropriate to utilise easements and it is positive that this is reflected in the national guidance. Additionally, the role of commissioners in co-ordinating relevant information with respect to the experience and capacity across independent sector social care providers (both private and voluntary sector) and relating to direct payments was also essential. It may be of benefit that the commissioner role is more clearly articulated in any future update to the national guidance. It may also be helpful that as democratic representatives, councillors are engaged in pre-planning for the possibility that Easements may be necessary.

59. Some felt that the national guidance was open to interpretation which increased the risk of challenge for individual councils right at the point of crisis. This is unhelpful. Additionally, there are several points where clarification would be beneficial, before any further peaks and/or Winter pressures are experienced, when the easements may be needed again. Two examples are:

a) many people's day opportunities services across the country were stopped, yet even where these were originally put in place against assessed needs relating to Care Act duties, and some councils operated easements due to this, very few councils considered easements were needed in the event of an apparent breach of those duties.

b) support for carers was reduced in many areas (including respite care in care homes), and legal clarity would be helpful on whether councils should utilise easements to facilitate these changes.

60. It is essential to be mindful of the interface between the Care Act Easements and other initiatives, hospital discharge, testing, PPE, workforce, mental health, CHC, MCA/DoLS, safeguarding. The messaging about other emergency powers and whether they are in place at a particular point must be clearly communicated. There was a particular issue raised by one area, where S12 doctors refused to act for a period, because they believed it was not legally compliant to assess remotely and the local authority had to source independent doctors.

61. There are definite lessons to learn about the national arrangements for testing and for the distribution of PPE and equally the decision to discharge COVID-19 positive patients from hospital to residential care homes prior to test results being available created significant criticism at a national level and potentially subjected care home residents and staff to heightened risk of infection spread.
62. Earlier, more proactive national responses and support to social care in terms of training, testing, PPE distribution may have resulted in reduced anxiety for social care recipients and staff around infection spread.
63. More regular and better refined NHS demand modelling would have supported social care to better plan for increased pressures and supported swifter and more confident worst-case scenario planning
64. At the same time as ensuring clear, regular communications, the Government also needs to consider the balance between regular communications and the plethora of fragmented guidance, regularly updated, so that it is difficult for professionals to keep up with the latest versions.
65. Even though COVID-19 is recognised as different from pandemic flu and that previous pandemic preparation may not all have been relevant to this pandemic, more pandemic preparation and clear, thought-through, informed strategy should be in place to enable a reduction in guidance on the hoof that has to be updated so often.
66. In times of real crisis, when local leaders are already fire-fighting, there should be a clear principle of “No surprises” and minimal requests for unnecessary additional reporting. In relation to the Care Act Easements the expectation on local authorities to widely consult with stakeholders was not realistic given the unprecedented nature of the Pandemic and the need to act swiftly and decisively.
67. Whilst it is clear that these were unprecedented times it would have been easier to respond to the pandemic if there had been more consistent and timely advice and information from central government and Public Health England. The key asks were on matters such as PPE, testing and funding, which all impacted on the ability to meet Care Act duties and to support the local market.
68. The essential relationship between the DASS and DPH and the data they both need to do the job is crucial.
69. Consultation and communications at a local level is crucial. Some national work was undertaken which would have been much better done at a local level. Some local systems were over-ridden by requirements to use national communications and then reverted to local management. Some regions had sophisticated data and intelligence systems that were over-ridden by national requirements. The sector needs national frameworks and permissions, which support local implementation and prioritisation. National messaging is required for the public and stakeholders to support the sector at a local and regional level.

70. ADASS branches have worked together throughout, and it may be beneficial to further explore regional approaches to easements in terms of shared capacity, mutual support and joint discussions with health, housing and other services.
71. Many Freedom of Information requests and the threat of judicial reviews made an already difficult, crisis situation much more hectic. Some rights groups pressed to stop easements, pursuing councils to provide information in order to 'protect rights'. This approach, whilst understandable, might in fact undermine those same rights because it risks what is happening in other areas becoming less transparent. This issue started to emerge later in the pandemic, for example, as reported in the article: 'Concern more authorities are easing care duties than saying' Professional Social Work Magazine, pg. 8, June, 2020.
72. Given the difficulties in implementing the requirements of the national guidance, at speed and in a crisis situation, it has been suggested that some areas may not even have tried to progress the Care Act easements because it was too difficult and the perceived risk of a 'process-related' legal challenge or political difficulty was seen as too great. This leaves a risk that some could have been operating easements informally.
73. There is a residual sense of injustice. DASSs who implemented the easements felt obliged to keep explaining themselves and justify their actions, even after they had done all that was asked of them in the guidance, with a genuine intent to be transparent. Some questioned why the reaction was so different from the reaction to NHS acute hospital service cancellations? Associated with this was a sense that despite the government department overseeing adult social care being the Department of Health and Social Care (DHSC), that department was perceived as overly focused on the NHS, and within that, "hospital-centric", to the exclusion of the wider health and care system, and that this contributed to a lack of public understanding of the wider system, and adult social care, in particular.
74. Whilst the picture has now changed somewhat, it would have been helpful to have better national and local public-facing communication regarding the expectations on local government and social care in particular. This would have been helpful to redress the imbalance between how the public initially valued the NHS contribution to the pandemic alongside that of Adult Social Care.