British Journal of Social Work (2021) **51**, 1879–1896
doi: 10.1093/bjsw/bcab080
Advance Access Publication May 11, 2021

Social Work Practice with Adults under the Rising Second Wave of Covid-19 in England: Frontline Experiences and the Use of Professional Judgement

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Abstract

The impacts on adult social work in England of the Covid-19 pandemic were sudden and are proving long-standing. In England, many social workers moved to home working and virtual contact with colleagues, managers, staff from other agencies and service users. A first national lockdown was followed by a lessening of restrictions, but a second wave started at the end of Summer 2020 and restrictions were re-introduced. This study draws on telephone interviews with a sample of twenty-two social workers working with adults in a wide range of roles and settings in ten local authorities and two National Health Service Hospital Trusts, interviewed August–October 2020. Following transcription, interview data were analysed thematically. Findings are reported under three emerging themes: using professional judgement, new and emerging case work and embedding change. These are compared with findings from studies of practice in children's services and of surveys of social workers during the Covid-19 pandemic. Implications for practice, service users and research are explored.

Keywords: adults, Covid-19, England, practice, social work

Accepted: April 2021

Teaser text

The impacts on adult social work in England of the Covid-19 pandemic were sudden. Many are lasting a long time. In England, many social workers started to work at home and talk to people by phone or online. The UK's first national lockdown was followed by a lessening of restrictions, but a second wave started at the end of Summer 2020 and restrictions were re-introduced. This study reports on telephone interviews that took place August–October 2020 with twenty-two social workers working with adults in a wide range of roles. They were employed in ten local authorities and two National Health Service Hospital Trusts. We discuss how they were using professional judgement about cases; what was new in their case work, and what changes they thought would last or be only temporary. These are compared with findings from other studies of practice in children's services and from surveys of social workers during the Covid-19 pandemic. This study adds new knowledge about practice in adult services and people's experiences during the emerging second wave of Covid-19 in England.

Introduction

Background

The Covid-19 pandemic is affecting the UK significantly. Cases first peaked in early April 2020 when a national lockdown was instigated, then fell from May to early July and social restrictions were lessened. From August, however, daily cases rose, and, at the time of writing, the UK was in the severe grip of a second wave (January 2021). Among the high number of deaths have been many people receiving adult social care (Comas-Herrera *et al.*, 2020) and members of the social care and social work workforce. As the pandemic developed several studies from across the world of social work practice have emerged, many taking unique national perspectives and with different aims, methods and underpinning theoretical backgrounds. These include interviews with practising social workers in Barcelona during the first fifteen days of the pandemic (Redondo-Sama *et al.*, 2020), interviews from England's children's services (Baginsky and Manthorpe, 2020a; Cook and Zschomler, 2020); an international survey of ethical challenges in practice (Banks

et al., 2020), and exploration of Canadian practitioners' use of technological innovations (Mishna *et al.*, 2020). Other studies have explored stress among social workers (Ben-Ezra and Hamama-Raz, 2020), while wider human services workforce studies have captured early experiences (Nyashanu *et al.*, 2020) or are enabling longitudinal comparisons of stress, resilience and occupational support (McFadden *et al.*, 2020). Discussion, editorials or expert opinion publications are emerging (Berg-Weger and Morley, 2020), several arguing that social workers should become involved in decisions, prioritisations and to promote social justice (Walter-McCabe, 2020) presently and in a post-pandemic world (McPherson, 2020; Strier and Shdaimah, 2020).

Relevant to the English context of social work practice, Baginsky *et al.* (2020) found that those working with children and families were taking different approaches to child protection to minimise risk of the virus but there have been few studies of practice with adults to consider its contribution and challenges. Most social workers in England are employed by local authorities (LAs) with services generally organised to support children and families or adults and so practice might be expected to vary. This article reports findings from a study that investigated practice experiences among social workers working with adults during the emerging second wave of the pandemic in England. The aim is to consider their accounts during this specific time, adding to the evidence from practice to assist in learning, service redesign and professional reflection.

Methods

Study design: the study from which the data reported here emerged had an initial focus on social work practice under the Care Act 2014 in England and its impact on adults with experiences of homelessness and self-neglect. This multi-methods study was funded by the National Institute for Health Research (NIHR) School for Social Care Research and its work packages include scoping reviews, documentary analysis, the use of case vignettes, fieldwork in three study sites including interviews with professionals and people using services, and economic modelling. An initial series of face-to-face interviews with frontline social work professionals was planned, prior to undertaking case study fieldwork, with options to conduct these interviews according to participants' preferences. The advent of Covid-19 affected fieldwork and these interviews were re-scheduled to take place by telephone late Summer 2020; with interview questions augmented to take account of the opportunity to explore practice under the pandemic and to hear from this convenience sample of their current experiences during this time. As Lupton (2020) predicted, qualitative research would have to adapt to virtual or

telephone interviewing and this study was no exception. This article reports participants' experiences of current practice as the second wave of Covid-19 was fast developing.

Data collection

A semi-structured interview schedule was initially devised prior to the emergence of Covid-19 consisting of a range of questions focusing on working within the Care Act 2014. As noted, new questions were asked about the impact of Covid-19 on practice because this subject was anticipated to arise and it was hoped that the interviews would offer rich data from the emerging second wave of the pandemic in England, exploring, for example, if changes following the first lockdown were being sustained. We were conscious of the imperative to avoid research burden as cautioned by Vindrola-Padros *et al.* (2020a) in their account of rapid qualitative studies during times of crisis. Recruitment was undertaken by circulating an invitation to participate in our study through a national social work knowledge dissemination network. The invitation did not specify an interest in or experience of working with people who are homelessness but did invite responses from social workers with an interest in self-neglect. We sought a sample of social workers working for different employers in urban, sub-urban and rural settings and in different adult social work roles. Our intended sample size was twenty so we prioritised offers of assistance more than this by seeking a wide range of employers and practice settings. In the event we undertook twenty-two interviews to include a breadth of participants. No reminders or follow up invitations were needed.

Following informed consent, with participants returning signed consent forms by email, all interviews were conducted by telephone by one team member (JH) between August and October 2020 at participants' convenience. All were audio-recorded with consent and fully transcribed. Interviews lasted from 30 to 65 min. All participants were offered a certificate of participation in research. Transcribed data were entered into NVivo data analysis software.

Data analysis

The research team (with backgrounds in social work and health services research, economics and an expert by experience) met online regularly to discuss study progress and emerging findings. Data were analysed by two members of the research team (JH and JM) and subjected to thematic analysis, drawing on the pragmatic principles of Framework Analysis (Gale *et al.*, 2013). Qualitative analysis is an iterative process

that sees data collection as integral to the process of data analysis. In these interviews, it was significant that the interviewer was consistent, and that the pandemic did not need explaining and was acknowledged as affecting all. This facilitated rapport and enabled the researcher to probe as appropriate for elaboration and to identify points of importance during the interview itself. The formal process of data analysis used the interview topic guide as a starting point and transcripts were repeatedly read to ensure familiarisation with the data. A coding framework was developed according to the strength of each theme, how frequently it was mentioned and how it related to the research topic.

Emerging themes were coded inductively throughout the analysis and added to the coding scheme. Team discussions ensured new codes were checked and validated to maintain consistency of coding. Data were further analysed for this article using key word automated text searches within NVivo to interrogate practice experiences, for example, of hospital discharge arrangements, assessment, multi-agency working and changes in caseloads.

Ethical permissions

The initial request for a favourable ethical opinion from the Health Research Authority's Social Care Research Ethics Committee for the whole study was greatly delayed due to prioritisation of Covid-19 focused clinical studies, so minimal risk ethical approval was obtained from King's College London, which enabled the initial telephone interviews with professionals to proceed with appropriate permissions. Attention was paid to ensuring procedures were in place if participants became distressed, or disclosures were made about clients being at risk. All documents were reviewed by the expert by experience who is a co-investigator in this study (SB) and by the practitioner representative (BO) on the research team.

Findings

Recruitment of sample

A total of twenty-two participants was interviewed; recruited from ten LAs and two National Health Service (NHS) Hospital Trusts employing social workers from diverse locations in London and the South of England. LAs spanned inner city, suburban and rural localities. Of the twenty-two participants, five were based in hospital teams, with the rest in specialist or generic adult social care or multidisciplinary teams in the community. While most participants were registered social workers, one was a senior social work assistant. Twenty-one were females and one

Table 1. Participants' roles, locations and demographic details ($n = 22$).

Interview participant	LA or NHS Trust	Participant (P)	Gender identity	Age group	Ethnicity
Approved mental health professional	LA1	P1	Woman	40–49	Asian British
Social worker/navigator, homelessness team	LA1	P2	Woman	20–29	White British
Social worker, hospital social work team	LA2	P3	Woman	40–49	Black British
Assistant team manager, mental health/out of hours	LA3	P4	Woman	30–39	White British
Social worker, single point of access, hospital team	LA4	P5	Woman	30–39	Black British
Manager, community safety team	LA5	P6	Woman	50–59	White British
Social worker, locality team	NHS Trust 1	P7	Woman	20–29	White British
Deputy team manager, adult disability team	LA6	P8	Woman	30–39	White British
Social worker, adult social care team	LA7	P9	Man	50–59	Black British
Social worker, reablement services	LA5	P10	Woman	20–29	Asian British
Social worker, adult social care team	LA8	P11	Woman	20–29	White British
Social worker, community mental health team	NHS Trust 2	P12	Woman	20–29	White British
Social worker, hospital integrated discharge team	LA6	P13	Woman	30–39	Asian British
Social worker, locality team	LA5	P14	Woman	30–39	Asian British
Social worker, locality team	LA8	P15	Woman	20–29	White British
Manager, adult mental health team	LA9	P16	Woman	40–49	White British
Liaison and diversion practitioner, NHS Trust	NHS Trust 2	P17	Woman	50–59	White British
Senior social work assistant, locality team	LA5	P18	Woman	20–29	White British
Manager, specialist team	LA4	P19	Woman	40–49	White British
Social worker, assessment team	LA10	P20	Woman	30–39	Black British
Social work manager, mental health, team	LA2	P21	Woman	40–49	White British
Social worker, hospital social work team	LA1	P22	Woman	20–29	White British

was male. Six were working in manager or team leader roles. Table 1 provides participants' relevant details, job titles and locations. Participants are referred to as them/their to safeguard their anonymity.

Using professional judgement

A strong theme from across the different locations of practice emerged of social workers following their professional judgement about taking

further action or in making risk assessments and decisions. Several examples were given of deciding, exceptionally, to make a home visit to see the service user or a person who had been referred to the LA, sometimes because other agencies would not make home visits:

> (the agency will say) well, no we don't do home visits at the moment, we only do telephone calls and things like that or things through zoom' but it's like 'this guy doesn't have an internet connection' you know and he barely has any credit on his phone at any point so the only way you're going to have to be able to engage with someone like that is by face-to-face contact. P11

However, the exercise of professional judgement was also described as a following a 'feeling', backed up perhaps by some practical justifications, as in this example from a participant working in a mental health team:

> Most assessments have been done via phone but if we feel that is not right or it would be not in the person's best interest, you know they couldn't get here or they were worried, or they didn't talk, some people don't like to talk on the phone or you know, we have still here been going out to do visits or assessments but of course wearing the full PPE (personal protective equipment). P16

While such reasons could be both 'feeling' based or practical, or a combination of the two, such decisions seemed to be made individually as one social worker, who had been hospitalised with Covid-19 in the early weeks of the outbreak and was back working, commented: 'Personally I try to visit my clients, those that are known for self-neglect, making sure that I've put my protective equipment' (P9). This participant observed that for some of their colleagues making a home visit might put themselves at heightened personal risk, for example, if they had health problems. For others, the context was necessary to consider in an assessment—to see the person but also their home:

> Oh so it's been a complete pick'n'mix, so we have, well I have been doing face to face visits because there are certain cases where you have to do that, you need to see the person, you need to see what's going on in the home environment. There are other cases that we've been able to do or I've been able to do over the telephone, even video calls. P15

As well as initial assessments, there were ongoing cases where a visit might be thought justifiable. In one example, a social worker had undertaken a virtual assessment for a Deprivation of Liberty Safeguards order under the amended Mental Capacity Act 2005 that had not been entirely satisfactory in their view and they intended to visit the individual, despite the risks to themself of visiting a care home and risks to residents:

> . . . we've been prompted to undertake the assessments virtually, so that could be via you know various social media resources available, that itself brings its challenges, it's not as straightforward and easy to have that communication with somebody. I'm actually facing that right now as we speak, I was talking to somebody this morning and I did do a virtual assessment a few weeks ago but I, now things have started to settle a bit, I'm actually going to see them in person on Friday. P10

In other instances, professional judgement was being exercised by the placing of trust in certain home care workers or colleagues from agencies such as the NHS in whom the social worker had confidence that they would be alert to any concerns or changes and would inform the social work team. While Covid-19 had affected the functioning of other sources of intelligence, such as day centres and other voluntary groups, some services were still running.

There were other examples where professional experience assisted in formulating a professional judgement. In one example, a social worker described the need to 'see with your eyes' when on a telephone call compensating for lack of personal encounter with the individual to inform the assessment. Such a skill was thought to come from experience and deep listening. However, another example emerged of a social worker feeling that their professional judgement was needed to counter possible inadequate practice by other professionals. This was articulated by a social worker who worked in a rehabilitation team (also quoted above in reporting their decision to visit a care home resident). They were concerned that the emphasis on expediting rapid hospital discharge was leading to incomplete summaries of patients' needs and circumstances:

> I've always felt deeply uncomfortable with that and raised my concerns about it and how information can be missed and how we should always make sure that the person is at the centre of everything and that they know exactly what decisions they're making, so I've always seen, I've always seen my patients whether that puts me at risk of Covid or not, I wear the relevant PPE (personal protective equipment) and I will go to the ward. P10

In this example, professional judgement was being made about the whole system of the Discharge to Assess policy, issued as government guidance in the early weeks of Covid-19 (Department of Health and Social Care (DHSC), 2020) although it was previously being used in several areas.

Overall, there was a sense that participants were exercising professional judgement by themselves, reliant on feelings and professional experience, conscious of the dangers of missing information. Those working at home did not mention discussing this with colleagues and contrasted their greater autonomy to pre-Covid-19 situations where their

manager, supervisor or colleagues would be easily accessible. For some who were working in the office, there seemed to be more of a 'team culture' about discussion and decision-making. Virtual mentoring had been put in place for participants working at home who were new to the profession or new to a team, with neither the experience to draw upon nor the office 'culture' to set the parameters of being able to make professional judgements about such a clearly important aspect of social work practice, that is, the need to see and talk to a person and build up some relationship.

New and emerging case work

In this theme changes in demand for social work services are illustrated, and also the context in which such referrals or increased levels of need were playing their part, several months after the initial national lockdown and as the UK's second wave was developing. There seemed to be three levels of demand. First, 'surfacing demand', were people who prior to Covid-19 had care and support needs but were being well maintained by contact with local voluntary and community groups or services, some of these informal, others more formally organised such as outreach from day services:

> I think once the lockdown eased then you started getting like complaints … but during the, yeah but during the lockdown people were really, really quite strong and actually many of them actually have, they were able to tap into their own resources that they have, whether that would be through their own friends or what have you but yeah it was good in that sense, a lot better than I thought it would be. P19

Some were unknown to LA adult social care, possibly because they were ineligible for services on grounds of lack of sufficient need or because they were above means-tested thresholds. Covid-19, however, had jeopardised their position, and needs were now coming to the LAs' attention, either as self-referrals but also following concerns raised by neighbours who were now keeping 'an eye open' for vulnerable people locally. Other referrals were coming from family members who had taken on caring tasks during Covid-19 but now were resuming their previous commitments or were exhausted:

> … there's an increase of referrals from carers at the moment where you know, 'I moved in with my mum and now I've got to go back to work so I've got to hand it over, I want someone to come out and assess her', so the referrals have increased as well. P10

Some participants noted a pickup in the pace of referrals because of the above, but there was a second group known to LAs whose needs

were growing or assuming more importance ('rising demand'). Such former or 'old clients' might have been managing but were becoming deconditioned by isolation and consequent lack of social interaction, exercise and stimulation. One participant reported the distressing numbers (four) of suicides among their team's caseload which they attributed to relapses during the previous months. Another participant working in a hospital service also noted increasing relapses:

> We're in the second wave now so for those that have been self-isolating and as they come in … they've got access in the community, we're seeing more of them having relapsing their mental health, so they're coming into hospital more yeah, whereas before you know we had the Mental Health Team and they used to go and do regular visits, some of our colleagues were doing telephone contact which is not the same yeah. P1

A rise in the complexity of cases that were being carried by the team's unqualified staff because of Covid-19 related pressures was mentioned. This was leading to pressures to support non-qualified staff:

> So, at the beginning of Covid the cases was a lot slower but half way through Covid things have got very, very busy and the cases are much more complex and we're working with people for a lot longer because they've lost that face to face with the Community Mental Health Team but our team are still doing face to face, yes filling in the gaps unfortunately.… our Support Workers each have more complex cases coming through and that's much more difficult because of the lockdown and people not being able to access their normal support services such as going to the Gym or the Library or really minor things that might seem really small but have a huge impact on their lives if they're not able to access those different types of support. P17

There was less emphasis on a third group ('unanticipated demand')—new to LA contact and newly perhaps in need of care and support; among participants who mentioned this were those who described new referrals to their LAs that seemed to relate to possible adult safeguarding concerns—from abuse and neglect associated with the pressures or opportunities of the pandemic—or problems with substance misuse following 'coping' with the pressures. However, practice was not very different from that prior to the pandemic in that initial inquiries/referrals were being made by telephone. A variety of reports about new, unexpected demand was made, with some participants reporting less, average and more demand or feelings of busyness:

> So, we have seen an increase in referrals since Covid, we've been extremely busy, and we've had a number of 'safeguardings' (referrals) or for self-neglect and for domestic violence. P21

Embedding change

In this theme we grouped together experiences of changes to practice following the sudden changes after the first national lockdown in Spring 2020. Participants provided examples of new practices that seemed to be embedding and other elements predicted to survive post-Covid-19. At the time of interview, with a second wave emerging, a post-Covid-19 world was envisaged but was not immediately in sight (vaccine programmes had not yet been announced). One almost unnoticed change that had become part of general conversation about practice and was not remarked upon was the accessibility of personal protective equipment (PPE). This was casually mentioned ('I've permanently got a PPE supply in the car' P1), and phrases such as 'donning and doffing' (taking gowns, masks and foot coverings on and off) were used as familiar terms for which the interviewer would not need explanation.

Meetings were now referred to as happening virtually by default, and generally not too difficult to organise, with a couple of exceptions. Generally, meetings involved professionals from other agencies; with a specific purpose in mind, such as information sharing to help decision making or to discuss 'high risk' cases. Familiarity with online meetings had been steadily growing over the months, although some regrets were expressed at what might be being missed:

> … it seems to work really well; people seem to have got used to it. I think it's a lot easier say, from what I'm hearing round the office, it's a lot easier for people to attend because those are virtual whereas in the past because people were actually having to turn up for meetings, a lot of the time people couldn't fit it in their calendar whereas you can, even if you can't attend the whole meeting, you might say be able to sit in for ten minutes and talk about the particular person that you're working with and that seems to work really well in our area. P2

> I think we're getting better at them, I think six months of doing everything virtually I think is getting better, in some ways you sometimes get better attendance at some meetings because they're virtual, so we're not asking people to come out of their office, travel, come to a meeting you know and all of that, they can just dial in as they are, so in some ways I think the move to virtual meetings is possibly helpful. In other ways you lose some of the general sort of discussion around a case, we tend to be more pointed I think in virtual meetings, so you lose some of the discussion around a person I think sometimes, but then that's in the skill of the person that's chairing the meeting as well. VHS6

Very few mentions of Information Technology (IT) problems were heard, only one participant referred to this, giving it as their reason for wanting to be office-based. This reliability fostered confidence in using

IT for multiple purposes, one of which was keeping in touch with colleagues to avoid isolation:

> I think initially, in the initial stage of the pandemic there were a lot of workers feeling quite isolated of this because they've become so dependent of working in an open plan office where the team is just you know sitting next to you or sitting behind you or you could drop somebody an email. You've gone into a virtual world so it kind of like, it magnifies and it brings out problems of its own which we're working through, we're working. You know how do you work collaboratively? I mean I'm so thankful for social media in this day and age, if we hadn't got that you know I think it would be a totally different challenge that we'd be looking at every day. P10

Another use of IT was for training, which had become online, whether this was continuing professional development (CPD) or training about new arrangements. Some training had been developed 'in house' by practitioners themselves using an easy to access link and was personally presented:

> We had started doing some face-to-face training, obviously Covid came, wiped that out, so we've got a 15 minute video … people can watch about the sort of context of it and how to use it and then they get advice about, that they can … how they can ask for help, they can come and ask me if they need some help. P6

Another change noticed was the greater use of voluntary and community groups, especially neighbourhood-based mutual aid groups that had sprung up to provide support, some of which could be accessed via social media:

> … in response to the pandemic, there are many organisations and many charities who have come forward that have really stepped up you know to provide that voluntary support, it's about tapping into those kinds of resources, many people in the community have opened up care and support groups which are informal, so neighbours, friends popping in, trying to drop shopping off, a lot of this is available on social media, whereas on a normal basis we wouldn't really be that dependent on social media but under this current pandemic we've been looking at social media, we've been looking at new ways of working collaboratively with the community … P10

For this participant contacts with these groups were a change from the previous patterns of referrals to the NHS, other parts of the local authority or more formal voluntary groups. Whether capacity would last long term was uncertain, but they appeared to be helpful to practitioners in several localities and worth fostering. Accompanying this however, some regrets were expressed of decline or changes in other forms of community support, such as lack of face-to-face befriending.

Three participants talked of legal, regulatory or national policy changes that were not as short-term as previously envisaged. The first revealed their anxiety regarding legislation passed early in the pandemic (the Easements amendments to the Care Act 2014 by the Coronavirus Act 2020, which granted the UK government emergency powers to handle the pandemic, initially for two years from 31 March 2020 subject to review, including the suspension of some Care Act 2014 obligations) permitting possible prioritisation of cases if certain circumstances prevailed:

> I don't think I've ever read the Coronavirus legislation or parts of it because it is about 780 pages but the excerpts that I have read to it is quite frightening, it feels like, like the Local Authorities do not have to fulfil their duty of care with anything, that's really … they are fulfilling it right now but they don't have to. If there's another second wave or so they say, if their budgets, because they're already going bankrupt or you know deficit from what happened over the last couple of months, if it happens again I think that they will prioritise people in a very, very different way. P19

However, there were frequent references to general permissiveness around practice, such as being able to conduct 'virtual assessments' (P10) and to do more tasks by telephone. It seemed likely that this would remain.

A second participant highlighted changes in guidance about hospital discharge, evidently referring to the Discharge to Assess model that had been instituted nationally in March (Department of Health and Social Care (DHSC), 2020) to aid rapid discharge by enabling assessments to be carried out after leaving hospital. They considered this would remain:

> So that form was introduced at the point of the pandemic and a new team was created to try to get people out of hospital at the same day, so that form was basically in the place of an assessment where you refer for care based on that form, but to be honest it's always relevant to the 'discharge to assess' model, but some people they need their assessment in hospital before they go to make sure that they're safe … I have problems with the new way of working and I feel like the pandemic was used as an excuse to get that kind of change in. P13

Associated with this was a further element that was thought unlikely to remain. From 19 March 2020 a commitment had been made for the English NHS to pay for post-hospital care without a financial assessment to assist rapid discharge, under Covid Hospital Discharge Service Requirements. One participant, P4, remarked that over 200 people in their local area had '*basically been put into residential care or a nursing home and we haven't given a **** about who's paying for that because it's not us, it's Health, it's Health's money*'. They envisaged that the temporary suspension of financial assessment would bring complications

once NHS funding was no longer forthcoming as individuals and families were likely to react negatively to having to pay for care.

A third change mentioned was the national commitment ('Everyone In' (March 2020), subsequently 'Protect Programme' (November 2020)) to provide accommodation to homelessness people, particularly rough sleepers (street sleepers) or those in congregate hostels. This was welcomed, but they did not know if it would continue to be resourced:

> Covid-19 has changed things because obviously we had the Government guidance of getting everybody off the street, so that, for me I think that was a fantastic thing and I think, you know I'm a great believer in Maslow and I think if you haven't got a roof then you haven't got any hope in hell of making changes and starting to have some settlement and I think without that it's very difficult to have other things kicking in. P4

Discussion

Strengths and limitations of this study: while this study interviewed twenty-two social workers in a range of roles, and settings, it is limited in being non-representative and other experiences may be forthcoming from larger samples. The interviews addressed a range of subjects as well as practice related to Covid-19 experiences and further time may have elicited more data. As with any interview, there is a risk of participant bias in that volunteers may hold strong views. Its strengths lie in its span of participants and a focus on practice at a specific time (second wave and prior to vaccine programmes being announced) thus contributing to the social work evidence base. All interviews were conducted by one researcher helping with continuity and subject familiarity.

There are overlaps with studies of social workers in children's social care and our findings (Baginsky and Manthorpe, 2020b). These share a general welcoming of working online for the conduct of meetings but show reservations about limited face-to-face assessments both in terms of reduced quality of information but also as undermining the development of relationships. Cook and Zschomler (2020) noted that in children's services exemptions to the no-visiting guidance seem to be satisfactorily discussed on a case-by-case basis and elements of this view were prominent in this present study, however the practicalities and the ethics of doing remained questioned, as suggested by Banks *et al.* (2020). With adults, many of whom will have high level risks owing to advanced age and prior health conditions, perhaps their generally much higher risks of contagion may have been more prominent in the minds of this present study's participants. This study adds to the literature a particular insight into the use of professional judgement and discretion in terms of face-to-face assessments or meetings that was reported by many

participants. While professionalism is characterised by autonomy, in this study many of the participants were home working, in contrast to many other 'frontline' professionals during Covid-19 who were hospital based (Vindrola-Padros *et al.*, 2020b). Taking this context into consideration may be of use when devising policy and guidelines since social workers appeared to think carefully through personal and professional risks and consequences and may see any fettering of discretion as undermining of good practice.

The general high-level functioning of LAs' IT systems was greatly appreciated in this present study as it was in children's services (Baginsky and Manthorpe, 2020a). For some there was further use of IT as a salve to counter professional and personal isolation when home working. Its use as part of training and CPD may be a step change.

This study suggests possible areas of new demand and heightened demand for social care services that were depressed in the early months of the pandemic and may be suppressed again following the increase in social restrictions as the second wave affects the UK. Importantly, it suggests some of the underlying reasons for this, such as family exhaustion and increased mental health stress among the public but also among people with prior mental health problems receiving reduced face-to-face support from other services. Interestingly, at this time there were no major indications of excessive workloads and no substantial critique of LA employers who seemed to be regarded as 'doing their best'. Access to PPE now appeared unproblematic, and there was no call for access to regular virus testing which at the time greatly concerned the direct care workforce (Griffin, 2020).

Larger surveys will produce findings based on validated measures about stress and resilience among UK social workers during the Covid-19 pandemic and some will be able to discern trends over time. McFadden *et al.*'s (2020) first (May–July 2020) survey (of a planned three) found social workers were more likely than other practitioners to have caring responsibilities so home life and work had simultaneously changed. Ben-Ezra and Hamama-Raz (2020) suggested that 'attention should be given to ways of operating with limited training and supervision during the pandemic and with the need for extra and/or different supervision in accordance with the exposure to distressing experiences both at work and at home'. Findings from such surveys covering home and work and from qualitative studies could helpfully be analysed together to build the evidence base for practice, social work organisation and training or skills development. There will be room for mixed-methods studies to also observe practice, analyse data from outcomes and service user accounts, and to build up further evidence for contingency planning for other possible emergencies. Social work will also need to address the impact on the profession of the pandemic, whether it attracts new entrants seeking to make a difference to people's well-being or

whether changes to practice dissuade potential applicants or render retirement a more attractive option. Such research will further need to engage with health studies that are seeking new ways of effectively supporting people with long-term conditions, disabilities or mental health problems who are often NHS patients but also have contact with social work services.

Conclusion

This interview-based study provides accounts of practice in English social work as the UK's second wave of Covid-19 pandemic took force. It offers insights into the use of professional judgement and observations about demand for social work services as well as evidence of changes that appear to be surviving the initial response. The profession may have been severely under-prepared for a pandemic in many parts of Europe (Redondo-Sama *et al.*, 2020), reflecting the rest of the UK, which suggests an imperative to learn from Covid-19 experiences to instil better preparedness.

Acknowledgements

We are most grateful to all the participants in this study.

Funding

This research was funded by the National Institute for Health Research (NIHR) School for Social Care Research. The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

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