Research Article

Reasons for Not Adopting COVID-19 Permitted Changes to Legal Duties: Accounts from English Local Authorities

Mary Baginsky ①, Emily Thomas ②, and Jill Manthorpe ③

King’s College London, London, UK

Correspondence should be addressed to Mary Baginsky; mary.baginsky@kcl.ac.uk

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In England, “easements,” introduced via the Coronavirus Act 2020, were brought in at the start of the pandemic to support English local authority adult social care services. They enabled local authorities to suspend some of their mandatory duties under the Care Act 2014. Easements were only adopted by eight local authorities and for short periods, and the provision was rescinded in late 2021. This article examines why a sample of 16 local authorities, some of which were statistically close to the eight local authorities that did decide to use easements, decided not to do so. It draws on data from interviews undertaken in 2021 with Directors of Adult Services and Principal Social Workers that explored their decision-making about using easements. It also outlines their preparations prior to the pandemic reaching England, how they had operated using “flexibilities” within the Care Act thus not needing to adopt easements, and their views on those authorities that had adopted them.

1. Introduction

In early 2020, COVID-19 was spreading rapidly across England, posing a serious threat to the population and to health and social care systems. To protect the adult social care system, the government eased local authority duties to the Care Act 2014. The provisions of this Act place a duty on local authorities to assess people’s needs and their eligibility for publicly funded care and support. Easements were intended to prevent potential legal challenges to local authorities (LAs) during the crisis on the basis that they were not meeting Care Act statutory duties, as well preventing inconsistent, and possibly ill-judged, decisions about people’s care and support (Department of Health and Social Care) [1]. To this end, Section 15 and schedule 12 of the Coronavirus Act 2020 amended LA duties in relation to adult social care. These provisions were given effect by the Coronavirus Act 2020 (commencement no. 2). Regulations from 31 March 2020 gave force to the Act’s statutory Guidance [2]. This Guidance details both the easements to the Care Act 2014 and the circumstances in which they should be implemented. Easements allowed the suspension of duties to assess needs, carry out financial assessments, and create support plans so long as they did not breach an individual’s human rights in the process. The Guidance was supported by a new ethical framework for adult social care [3].

Under the Guidance, LAs should first make use of existing flexibilities under the Care Act 2014. It reminded LAs that this Act allows them to assess, review, and prioritise in different ways. The Guidance detailed four stages (Table 1) and explained that easements were intended to allow LAs to prioritise the most urgent needs when the workforce was depleted significantly or demand on their social care services increased to a point when urgent and acute need risked being missed, risking lives [2], Section 6.

Duties to assess under the Care Act 2014 became powers to assess. However, until a LA had reached a crisis over staffing and/or faced being overwhelmed by demand, the intention was that the first two stages would be sufficient. The Guidance set out the process for taking the decision to use Stages 3 and 4 easements, giving a crucial role to the Director of Adult Services (DASS) and the Principal Social Worker (PSW) for Adults. Consultations were also required with the lead council member with responsibility for health and social care and local NHS clinical commissioning group
(CCG), as well as with others with a direct interest such as the Health and Wellbeing Board (HWB) and local providers and representatives of service users (for further details, see [4]). It was only when a LA moved to Stages 3 and 4 that the decision had to be conveyed to the DHSC and the local HWB. Alongside the Guidance, the government also published an “Ethical Framework” [3]. This contained a list of factors to be considered when decisions were made in adult social care, including respect, reasonableness, minimalising harm, inclusiveness, and proportionality (see [5]). Proportionality in this sense means that the assessment is “only as intrusive as it needs to be to establish an accurate picture of the needs of the individual or their carer, regardless of whatever method of assessment is used” [6].

There were widespread reductions and alterations to people’s care and support as the pandemic took hold [7] which were similar to those in other countries [8, 9]. However, these came on top of Dunn et al.’s [10] description of a prepandemic adult social care system in England that was “underfunded, understaffed, undervalued, and at risk of collapse” (p2). While this was leading to fewer people being entitled to publicly-funded adult social care, expenditure on social care was still rising. So, it was perhaps surprising that only eight English LAs invoked the use of easements; all doing so in the weeks immediately following the introduction of the legislation. In one LA, they were in place for less than a week and only two LAs used them to limit their duty to meet unmet eligible need (Stage 4). All eight had ceased to use them by 29 June 2020 and no other authority chose to do so before they were removed from the statute books in March 2021 following the one-year review of the Coronavirus Act 2020 [11]. The reasons why LAs adopted and then abandoned easements are explored in [12]. It is also important to understand what decisions were made in LAs that did not use them and to consider their reasons for not doing so, not least to inform planning for a similar scenario in the future.

2. Methodology

The data reported here are part of a larger study where literature and documentation on easements were examined, prior to interviews with key informants (KIs) across social care, law, health, and academia [12] and in LAs that had and had not adopted easements. It is the latter data that are reported in this paper.

Recruitment of LAs had decided not to adopt easements took place between April and September 2021. The intention was to construct a purposeful sample of LAs to explore specific experiences. Using the adult social care efficiency tool [13] which allows councils to compare themselves with similar councils or “statistical neighbours” on a series of indicators including expenditure as well as the quality and quantity of the services, five LAs were recruited that were the nearest statistical neighbours to those LAs that had adopted easements. Earlier interviews with KIs [12] had identified LAs that had been opposed to easements and, without breaching confidentiality, we contacted some of them to explore their views. We then examined the geographic spread of participant LAs across England and contacted senior staff in LAs in underrepresented regions. At this point there was also an element of snowballing as they then suggested others who might be interested in taking part. From a total of 23 LAs approached, seven either did not have capacity to participate or did not respond. Table 2 summarises the type of LA and participants by job role.

In nine of the 16 LAs participating, the Directors of Adult Services (DASS) and the Principal Social Workers (PSW) were interviewed together, including one where another senior manager in adult social care was present. In one LA, only the DASS was interviewed; in five, only the PSWs were interviewed; and in one LA, both were interviewed but separately. Other senior managers contributed to two of these interviews. The research team, all female, had backgrounds in adult social care and social work research and education. We used a semistructured interview schedule that was informed by the KI interviews, interviews with the LAs that had adopted easements, and document and literature searches. The interviews covered participants’ views and reflections on the state of adult social care before the pandemic, preparations made in weeks up to the national lockdown, the decision-making process around easements, and the demands made on adult social care during the pandemic. Where appropriate, questions some were tailored to the LA. All interviews were conducted over Microsoft Teams, Zoom, or Google Meet and lasted between 45 to 60 minutes. They were digitally recorded with participants’ consent.

Interview data were analysed manually. First, all transcripts were read to allow the researchers to familiarize themselves with the dataset. One researcher (ET) then analysed the data thematically, reflecting the main topics explored, to reach a deeper understanding of the views and experiences expressed (see [14]). A second researcher (MB) then reviewed these themes and recoded to combine and divide some themes, before analysing for common and shared views, as well as unique and minority perspectives.

The study received ethical approval from King’s College London’s Ethics Committee.

<table>
<thead>
<tr>
<th>Table 1: Easement stages.</th>
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<tr>
<td>Stage</td>
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<tr>
<td>Stage 1</td>
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<td>Stage 2</td>
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<td>Stage 4</td>
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3. Findings

3.1. Context and Challenges. It was evident from the interviews that all LAs were facing similar challenges prior to the pandemic. While all LAs were operating under public sector pressures [12], these varied in impact and were not equally onerous across participating LAs. The importance participants attached to them reflected local demographics, as well as their financial stability and level of affluence. Demands were increasing as a result of a growing older population and/or increasing numbers of working-age adults with a disability or mental health needs. Those LAs in affluent areas had more self-funders compared with those LAs with higher levels of deprivation meaning that the care market and those accessing it were largely outside its influence (see [16]). By contrast, two LAs (NE8 and NE10) were amongst the most deprived areas in England, and although there were fewer older residents, there was a relatively large younger population with high levels of need in terms of disability, mental health, and safeguarding. However, one of the most frequently mentioned challenges is facing LAs in the months before the pandemic linked with their own workforces. While some reported a reasonably stable workforce, others reported significant retention problems. In some LAs, specific local circumstances meant that the fear of provider failure (such as a homecare agency) had been requiring them to develop plans to minimise the disruption.

LAs reported a distinction between emergency planning undertaken before COVID-19, for example, to deal with events such as flooding and specific pandemic planning where, for the most part, emergency planning exercises and handbooks had not helped. One DASS said that these had “been thrown out of the window” (NE8) while another reported that while some aspects of “flu planning” were transferable to their COVID plan, it had not provided any guidance on establishing personal protective equipment (PPE) supplies or infection control and neither had the government (NE9). However, in the weeks leading up to the first national lockdown, starting on 23 March 2020, a substantial level of planning had taken place at local authority and regional levels. While there were structural differences, all LAs were key players in their local resilience planning groups or forums, multiagency partnerships of local public services, and senior LA staff were involved in a several different co-ordinating meetings delivering COVID-19 responses.

In this early period, most day services were closed, and in some LAs, the number of care home deaths was rising rapidly. More widely, there was insufficient PPE and limited access to COVID-19 testing. Where staff had technology that was compatible with remote working, the transition went smoothly, albeit with increased demands on IT systems and IT workforce. When IT hardware and software were not so good, money was immediately ploughed into rapid modernisation of systems and equipment. While some social workers still attended the office and made home visits where necessary, most assessments and other contacts were conducted remotely. Continuing Healthcare (CHC) assessments were suspended on 19 March 2020, and new hospital discharge requirements were published the same day, giving NHS and care sector the flexibility to adapt to local circumstances [17]. These circumstances led to a sharp increase in the number of people who needed LA assessments and reliance on a RAG-rating system to review and update the risk assessment on all cases. Stage 2 flexibilities allowed LAs to conduct assessments remotely and find alternative forms of care for people, as well as defer assessments, while other preventative services and community resources were investigated (see [18]). Many LAs reported using proportionate assessments to ensure the process was not overly burdensome. LAs reported working with care providers to deliver essential services and find alternative ways to meet assessed needs.

Many of these changes to LA services resembled changes reported by LAs who had used Stage 3 easements (Baginsky et al, 2022b). For example, one noneasement authority deprioritised its annual reviews by creating a waiting-list, and another prioritised requests for immediate need over long-term need which led to some outstanding reviews. Stage 3 easements meant that LAs did not have to prepare or review care plans, but they still had to carry out personalised

<table>
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<tr>
<th>Anonymised label</th>
<th>Type of local authority</th>
<th>Participant role</th>
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<tbody>
<tr>
<td>NE7</td>
<td>County council</td>
<td>PSW and social work manager</td>
</tr>
<tr>
<td>NE8</td>
<td>London borough</td>
<td>DASS</td>
</tr>
<tr>
<td>NE9</td>
<td>County council</td>
<td>DASS, PSW and two social care managers</td>
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<tr>
<td>NE10</td>
<td>Metropolitan area</td>
<td>PSW</td>
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<td>NE11</td>
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<td>NE13</td>
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<td>NE22</td>
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3.2. Perceptions of Easements. During this time, the PSWs were meeting regularly with the DHSC’s Chief Social Workers (CSWs) where easements were explained and later debated. The role identified for PSWs in the Guidance, alongside these regular contacts with the CSWs, meant that PSWs were central to the discussions that took place in LAs even though some admitted uncertainty about the processes involved in introducing easements or the consequences of using them.

A common response when asked their initial thoughts of easements was that they had seemed confusing, particularly when compared with the processes and guidance on the suspension of Continuing Healthcare assessments. Others talked of a proliferation of guidance at this time which, in their opinion, was not as clearly drafted as it could have been.

The decision not to use easements had usually been taken by LAs early on, generally driven by the realisation that the LA had sufficient flexibility to fulfil their Care Act responsibilities. But DASSs and PSWs did not act alone. It was discussed in LA executive meetings, with Council members and sometimes in other health and adult social care groups. LA legal teams advised on the flexibilities which LAs already had, and on proportionality, enabling them to understand what they could do within the Care Act, and under what circumstances they might have to use easements. In at least one LA, the decision was influenced by the perceived benefits of continuing to work within the Care Act when staff knew that system and where the LA would be able to construct an audit trail (NE9). They had concluded that there was sufficient scope for flexibility to allow streamlined assessments, for example, while still operating within the principles of the ethical framework [3] and maintaining a person-centred approach.

One DASS (NE12), a fierce opponent of easements, viewed them as a political move which provided at best a limited response to what was needed but failed to acknowledge the pressures on the sector. According to this DASS, there had been a widespread culture of Care Act noncompliance across local authorities prior to the pandemic, but they had also been concerning from the outset that easements would attract very negative reactions and that was not something with which they wanted to deal. There were others who were determined not to use them as they believed it was not the right road to take, even viewing it as a failure if they had done so. This was despite a widespread belief that the government had long failed to acknowledge that LAs always had more demand for services than they had resources to meet.

While some LAs were firmly set against their use, for others they had remained a possibility. A few DASSs and PSWs had seriously considered adopting easements in April/May 2020 when the infection and death rates were escalating, viewing them as “prudent” and “sensible” in an unprecedented situation:

It would be an absolutely last resort, and that we would do everything possible to minimise the need to actually seek approval to use easements (DASS, NE14).

However, this meant carefully monitoring a changing situation. In one LA, providers had been told to risk assess individuals while bearing in mind that easements could be a possibility (NE9). Other LAs, while wanting to avoid their use, had prepared in case they were required. One LA (NE16) conducted quality impact assessments to be able to judge the impact on various groups if easements were used and devised screening tools to identify their most vulnerable service users, and another LA (NE17) had devised a screening tool had been coproduced with service users. A few LAs had provided training for their staff on easements and/or British Institute of Human Rights training. There was a small number of LAs that had planned either a public consultation or a document for all service users that explained what it would mean if easements were introduced. However, one LA (NE19) had rejected a similar exercise in case it led to public concern.

Some DASSs and PSWs thought they had probably not acted that differently from most of the LAs that had adopted easements. One PSW (NE7) suggested that easement LAs may not have considered carefully enough what they were allowed to do by using the flexibilities within Stages 1 and 2 before taking the leap to easements. Another PSW who had discussed the decision with their equivalent in an easement LA did not think that LA had come anywhere near to meeting the criteria to trigger easements and that there they had been introduced as a precautionary step. McHale and Noszlopy [4] have identified the haste with which the legislation was introduced. Some participants suggested that a more rigorous scrutiny of the proposed Guidance might have identified the flaws in drafting and avoided confusion. This was particularly said to be the case at the interface of Stages 2 and 3, which had left some of those interviewed fearing they had acted illegally within Stage 2 and veered into Stage 3. One PSW (NE15) suggested that “ unofficial” easements had been used in their LA without the knowledge of senior managers and without a proper understanding of what an easement was. However, another PSW (NE18) was less concerned that this might have happened. They viewed easements as a reflection of government failure to recognise the ability of social workers to manage though this period and that they had probably moved into “easement territory” at times when they were appropriately prioritising work:

Easements had come from the good ideas club somewhere in government instead of saying “use your initiative, we understand that, get on with it, through the systems that you’ve already got”.

Wherever their views on easements, many DASSs and PSWs observed the contrasting ways in which the NHS and adult social care had been reported in the media and, more significantly, that the NHS had been given nationwide indemnity for clinical negligence liabilities in the Coronavirus Act 2020. They contrasted repeated
3.3. Local, Regional, and National Support. Easements were discussed at national and regional levels as well locally, and these contacts had enabled DASSs and PSWs to piece together what they believed was an informed understanding of what was happening across England. Legal advice on the implications of using easements was available from their own legal teams but, in one region, also from an Association of Directors of Adult Social Services (ADASS) regional group. One DASS (NE11) reflected that this amounted to “good moral support” as there was no roadmap for how to act or take decisions.

There were many references to the discussions with DHSC, Care Quality Commission (CQC), and ADASS, but many of those interviewed preferred consulting ADASS and regional colleagues than the DHSC. One DASS (NE9) considered that officials in the DHSC and the Department for Communities and Local Government seemed to have little understanding of the care sector or how it operated and only in discussions with ADASS had they come to understand how contentious easements might become. The disconnect that some felt between themselves and Government departments was compounded by their experiences over changes to key contacts and their perception that the Government tended to look to providers rather than LAs when deciding what needed to happen.

While easements were discussed in national PSW Network meetings, regional meetings appeared to be the most significant for PSWs. These meetings were described as a good source of support and a sounding board for possible actions. They provided the opportunity to share experiences of what was or was not working, compare, and share drafts of documents and policies and measure their own response against that of other LAs. In one network, a PSW had emailed PSW colleagues for support when she came under pressure to agree to the introduction of easements. It was not clear if this had been the reason why they had not been adopted but this LA had not gone ahead.

Two pre-existing arrangements seemed to help some noneasement LAs prepare for what might be ahead. Where there were well-coordinated and longstanding relationships with NHS partners, it had been possible to keep COVID positive cases out of care homes from an early stage and reduce infection levels when the first lockdown occurred. Similarly, those LAs with an established communication route to providers through an umbrella or representative body saw themselves as in a much better position to coordinate a response than where contact had to be established.

Noneasement LAs were aware of the criticism that easements evoked. While not cited as a reason for non-adoption, it may have been a disincentive for some. In one region there was an agreement that other LAs would not let any LA be in a position of needing to adopt easements by providing it with the resources that were in short supply.

4. Strengths and Limitations of the Study

Our interviews provided a window into the reasoning behind the decisions in some LAs not to use easements. However, we interviewed only a small proportion of LAs that did not adopt easements and their views may not be generalisable across the other 127 that took the same decision. It is possible that those interviewed may have had specific perspectives on easements; indeed, some were recruited to allow us to explore these. Nevertheless, the views expressed spanned a spectrum from those who were strongly opposed to the idea of ever adopting them to those who made contingency plans in case they had to be introduced. Perhaps one of the most significant limitations, not just of this part of the study but of the whole, is that we were not able to hear from service users. We had intended to speak with people impacted by easements, but it proved impossible to recruit anyone who had been affected. While we did not intend to interview service users in noneasement LAs, but we hope that the experiences reported here will inform and contextualise other research, such as that of Tuijit et al. [20] and Vera San Juan et al. [21].

5. Discussion

The word “unprecedented” in relation to events surrounding COVID-19 is regularly used and in danger of losing its value in this context. Nevertheless, it does describe the situation facing LAs in the early 2020 where the lack of pandemic preparation, and specifically its impact on social care, was exposed. Easements were designed to keep adult social care functioning and to enable LAs to continue to meet the most urgent needs during COVID-19 by relaxing some of their duties. The flexibilities permitted under the Care Act 2014 enabled most LAs to manage the demand on adult social care without adopting easements, but some of those interviewed suggested that LAs had sometimes used a form of informal “easements,” probably operating at the boundary of Stages 2 and 3. Our findings support ADASS’s [22] conclusion that the LAs that had used easements were not operating in a substantially different way to many of those who had eschewed the option. Most of the LAs that adopted Stage 3 easements were conducting remote assessments, delaying financial assessments, completing proportionate care and support plans, and suspending/delaying scheduled reviews [12]. This was in line with what we heard from noneasement LAs and, depending on how these changes were made, might have required a Stage 3 easement but might also have been covered by Stage 2. Only two easement LAs adopted Stage 4 allowing them to replace a duty to meet eligible care and support needs, or the needs of a carer, with a power to meet needs and they had only done so for a very short period.

So, what stopped more LAs declaring a Stage 3 move? While some DASSs and PSWs were morally and ethically opposed to “easing” the Care Act, even they could not continue normal operations so adapted services to the prevailing conditions of social distancing and home or hybrid working. Participants in other LAs thought easements could be useful, but they had tried managing without them as
enacting them could have added additional burdens on already pressured staff. However, many participants were also conscious of the criticism levelled against LAs that had adopted easements, including threats of legal challenges and a barrage of Freedom of Information requests. This awareness may have provided the invisible harness that had pulled them back from considering adoption, either initially or later in winter of 2020/21 when England’s second wave of COVID-19 was at its height.

The Guidance had been criticised for its ambiguity [22] and another reason for the lack of enthusiasm for easements was the confusion which the introduction of easements appeared to have caused. Even amongst some of the DASSs we interviewed there were those who confused Stage 2 usage with formal adoption of easements. Leaving the decision to use easements to local interpretation while simultaneously viewing easements as a last resort [23], left DASSs and PSWs, along with those they consulted, to define the meaning of last resort. It could be argued that local authorities were faced with even greater challenges over a year later. The Delta and Omicron variants in the autumn and winter of 2021-22 occurred when the possibility of adopting easements was no longer in place. LAs had to rely on the “flexibilities” to cope. Some LAs were forced to reduce people’s care packages during this time which would have required a Stage 4 easement had they still been in place. ADASS [24] reported that between 24 December 2021 and 5 January 2022, 49 LAs had adopted “at least one of the measures needed to prioritise care and assess risk that directors regard as least acceptable, i.e., prioritising life sustaining care such as supporting someone to eat and remain hydrated over supporting someone to get out of bed or complete other activities.” They were also not undertaking reviews and were reported to have “left people with dementia, learning disabilities or poor mental health isolated or alone for longer periods than usual.” (ibid). If easements had taken a different trajectory in the early stages of the pandemic, they might have still been in place and at least provided transparency around the reductions in services that were introduced.

Both legislation and Guidance on easements were constructed at pace, bringing well-recognised problems associated with expedited legislation (see House of Lords Select Committee in [25, 26]). Our interviews highlighted the lack of clarity and confusion that had existed. Moosavian et al. [27] argued that the Coronavirus Act was severely limited because it was emergency legislation and had failed to use the provisions of the Civil Contingencies Act (2004) or the Public Health (Control of Disease) Act 1984, developed prior to emergencies and with consultation and debate. A similar argument was made in a scrutiny report on the use of COVID-19 emergency powers [28].

6. Conclusions

The DASSs, PSWs, and social work managers whose views are reported here had chosen not to ease their LA Care Act duties. While most LAs in England did the same, responses to easements varied. Some said they had not needed them, while others considered using easements would be a failure or that they would be more of a hindrance than a help. Others had made preparations in case situations changed. All emphasised that the period prior to the COVID-19 pandemic had already been beset with challenges arising from austerity, increasing demand, and workforce recruitment and retention problems. Emergency planning, however, had been thin on the ground among LAs, and central government plans for a pandemic were considered inadequate. When the pandemic hit, LAs adapted quickly. DASSs and PSWs drew on legal advice and support and expertise from their networks, including neighbouring LAs, to construct what they considered to be legally sound responses. Many of these LAs had been very conscious of the criticism that had been directed at the early adopters and, for some, this may have been the deciding factor in not using easements. Instead, these LAs used Stage 2 “flexibilities” to make the necessary adaptations to their services to ensure they were able to function during a time of social distancing and increased demand, although it is possible that unwittingly they had exceeded what was allowed because of the confusion at the interface of “flexibilities” and “easements.”

In Australia, the response to COVID-19 included a National Management and Operational Plan for disabled people, with an accessible website for disabled people, families, and providers of health and care services. No such cohesive plan existed in England [29]. Participants felt that plans to support adult social care were not in place and that easements had been an inadequate solution to stop services being overwhelmed. In the event, most did not adopt them, and their reasons contain important lessons for planning for future emergencies.

Data Availability

Access to data is restricted in order to preserve anonymity of contributors.

Additional Points

What Is Known about This Topic. Local authority adult social care faced challenges in funding and resourcing its services prior to the pandemic, and these challenges were exacerbated by the COVID-19 pandemic. Care Act easements were adopted by eight of the 151 local authorities in England and only used briefly between the end of March and the end of June 2020. The Association of Directors of Adult Social Services in 2020 reported little difference between the measures taken by local authorities that used the easements and those that did not. What This Paper Adds. This paper identifies the lack of preparation for a public health emergency in local authority adult social care. The paper reveals how Care Act easements were received, understood, and prepared for by the local authorities that did not adopt them. It provides evidence of why local authorities did not adopt easements, placing their confidence in the flexibilities of the Care Act 2014 as sufficient means to meet people’s care and support needs.

Disclosure

The views expressed are those of the authors and do not necessarily reflect the views of NIHR School for Social Care Research.
Conflicts of Interest

The authors declare that there are no conflicts of interest.

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